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**Understanding the Gendered Effects of War on  
Women: Impact on Resilience  
And Identity in African Cultures.**

**By**

**Katie Sherwood**

**May 2009**

A Thesis submitted in partial fulfilment of the requirements of the  
Degree of Doctor of Clinical Psychology

Coventry University, School of Health and Social Sciences, University  
of Warwick, Department of Psychology

**BEST COPY AVAILABLE.**

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## **IMAGING SERVICES NORTH**

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## **Acknowledgements**

Firstly I would like to thank all the women who took part in this research, I was moved by your stories and inspired by your strength and courage. I wish you all the best for the future.

I would like to thank Helen Liebling-Kalifani for her support and for keeping me grounded during stressful times! Equally I would like to express my gratitude to Dan Barnard for getting me started, taking the time to check drafts and his general support throughout.

I would like to say a big thank you to the 2006 cohort from the Coventry and Warwick clinical course particularly Rowan Wigg, Angela Watts, and Sarah Simmonds for being part of the 'Facebook Thesis Support Network!' and to Rebecca Guhan for her support and reassurance throughout our time at the Refugee Centre.

Thanks are owed to my Mother who provided me with wine when needed and to my Brother for distracting me with Mario Kart! And a special thanks to my Father Ian to whom this thesis is dedicated, who never saw me complete my journey in training but who provided support and encouragement from the beginning. I miss you very much dad and know you are watching.

And finally a special thank you goes to Mark, who has never doubted me even when I doubted myself. I thank him for his patience, humour and unconditional love throughout my training. For being there when I needed him and being in Africa when I didn't!

## Declaration

This thesis has not been submitted for an award at any other University other than the Universities of Coventry and Warwick. This is the candidates own work.

This thesis was prepared with the assistance of under Dr Helen Liebling-Kalifani (Academic Supervisor), Dr Dan Barnard (Advisor) and in collaboration with Jane Longville (Manager of Refugee Centre). The study ideas and design rose from collaboration with my academic supervisor and the manager of the Refugee Centre.

Chapter One: Literature Review – *‘Understanding the Effects of Gender-Based Violence in Conflict Settings: A Review’* was prepared in accordance with submission guidelines for the Journal of Traumatic Stress (Appendix 1a).

Chapter Two: Empirical Paper <sup>1</sup> – *‘A Grounded Theory Investigation into the Experiences of Women War Survivors in Africa: Effects on Resilience and Identity and Implications for Service Provision’* was prepared in accordance with submission guidelines for the International Journal of Women’s Studies (Appendix 1b).

Chapter Three: Reflective Paper – *‘Experiences of Conducting Research with Refugees: Reflecting on the Process’* was prepared in accordance with the submission guidelines for Psychology of Women’s Section Review (Appendix 1c).

Ethical approval for the completion of the research reported in chapter two was obtained by Coventry University Research committee (Appendix 2a).

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<sup>1</sup> The Word count for this paper exceeds the limit of 8000 words however; guidelines for chosen journal shall be adhered to for publication. The overall word count for the thesis remains under the 20000 limit.

## **Summary**

Chapter one examines literature on the prevalence and effects of gender-based violence during war on women and men. Research indicates that physical, psychological and socio-cultural consequences of gender-based and sexual violence are fundamentally linked and have a differential impact on men and women's identities. Despite research demonstrating psychological symptoms of post traumatic stress as a result of these experiences, it is argued that applying a western medical model to survivors from non-western countries may not be the most comprehensive way of understanding their experiences. A model that accounts for the cultural context, gendered differences and identity impact is proposed. Very few studies reviewed addressed resilience and coping in survivors of gender based violence indicating a gap in the psychological literature.

Chapter two explores African women's experiences of violence during conflict and seeks to identify its impact on mental health. It also provides an understanding of the roles of resilience, coping and identity in African refugee women. Results identified a complex relationship between resilience, access to rights and support and identity in African refugees living in the United Kingdom. It also recognised cultural and societal influences in Africa and experiences in the UK as influential factors. Results from the study support the move toward an holistic model of understanding refugee women's experiences. The study also reveals the importance of support services assisting women to utilise a resilience framework to assist rebuilding their identities in order to maintain resilience.

Chapter three provides personal reflections on the research journey and process. Methodological and ethical issues related to conducting research with refugees are discussed. The paper also draws on emerging themes from a reflective journal, which highlights the challenges and positive experiences of the researcher whilst volunteering for a local refugee centre. It also makes suggestions about further considerations of these issues by Clinical Psychologists within research supervision processes.

Overall word count for thesis: 19973



## **Abbreviations**

<b>GBV</b>	Gender-Based Violence
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>WHO</b>	World Health Organisation
<b>UN</b>	United Nations
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNIFEM</b>	United Nations Development Fund For Women
<b>Isis-WICCE</b>	Isis Women’s International Cross-Cultural Exchange
<b>IDP</b>	Internally Displaced Person
<b>DRC</b>	Democratic Republic of Congo
<b>STI</b>	Sexually Transmitted Infection
<b>UNFPA</b>	United Nations Population Fund
<b>UNAIDS</b>	United Nations Programme on HIV/AIDS
<b>BPS</b>	British Psychological Society

# **Chapter One**

## **Understanding the Effects of Gender-Based Violence in Conflict Settings: A Review.**

**Target Journal: Journal of Traumatic Stress**

**See Appendix A for instructions for Authors**

**Word Count (Excluding abstract, tables, figures and references): 8023**

## **1.1 Abstract**

Empirical studies (n=23) exploring the prevalence and effects of gender-based violence (GBV) during conflict in men and women were reviewed. Research indicates that physical, psychological and socio-cultural consequences of violence are fundamentally inter-linked, having a differential impact on men and women's identities. Analysis of the literature reviewed suggests that although survivors of GBV may exhibit symptoms that can be understood within a Post Traumatic Stress Disorder (PTSD) diagnosis, it is argued that PTSD is a western diagnosis which does not adequately account for gender differences, and can be an incomplete model for understanding effects of violence in non-western contexts. Unfortunately very few studies address coping strategies in survivors of war violence despite acknowledging the fact that they are able to display extraordinary amounts of resilience. Methodological limitations and recommended directions for future research in this area are outlined.

## **1.2 Introduction.**

Violence has always been part of human experience; it is evident all over the world in various forms. Each year millions of people lose their lives or suffer non-fatal injuries as a result of violence during conflict. It is well documented that violence is widespread, however gaining accurate information on the exact prevalence is difficult (Refugee Council, 2009).

War causes physical and psychological, as well as cultural devastation. The term gender-based violence is used to distinguish violence that targets individuals or groups of individuals on the basis of their gender. Gender roles and expectations, male entitlement, sexual objectification and discrepancies in power and status have increased the prevalence of violence against women (Russo and Pirlott, 2006). However, men are also affected by violence both directly and indirectly. Perhaps the primary impact of war on survivors is witnessing the destruction of the social world embodied in their history, identity and living values (Summerfield, 2000). Physical, psychological and social aspects of people's experiences directly impact on their identities.

A lot of existing research on survivors of war has tended to focus on people in developed countries where adequate support is readily available. However in contrast, little attention has been given to those that survive conflict in developing countries, where sources of knowledge, services and support are distinctly scarce.

This review will critically analyse the literature on gender-based violence and build on international concepts from war-torn countries. Hence, in summary it aims to:

1. Conceptualise gender-based violence and the differential experiences of violence on women and men.
2. Critically analyse existing literature on the psycho-social effects of war on women and men.
3. Provide a critical review of some key literature on Post Traumatic Stress Disorder (PTSD) for understanding the effects of war on survivors and discuss alternative models for understanding the impact of the effects of violence in non- western contexts.
4. Review the methodological limitations of the reviewed research and summarise the implications for future research in this area.

### **1.3 Literature Search Strategies**

Several techniques were used to locate relevant studies for this review. Initially databases were searched between September 2008 and February 2009 for peer-reviewed published literature. Three main databases were included: PsycINFO, Medline (OVID) and Web of Knowledge. At the start of the process, only research published between 1999 and 2009 were reviewed, however key papers from as early as 1991 were used to inform more recent publications. Box 1 shows the main search terms used.

Search terms were cross-referenced and subsequently used to search abstracts, title and key words from the above data bases. Combination operators (AND, OR) were applied to the primary source citation results. Articles were then checked for duplicates and further excluded if not in English language. Reference lists of relevant articles identified in the first instance were then checked for further relevant publications. This process was repeated until no new references were identified.

Databases were checked again between February and April 2009 to incorporate any new articles.

**Box 1. Search terms used for online databases**

- Gender Based Violence, Rape, Violence, Torture, Sexual Torture
- Post Traumatic Stress, Trauma, Psychological trauma, PTSD
- War, Conflict
- Africa
- Refugees
- Identity
- Men OR Males
- Women OR Females

The lead author identified the most important themes emerging from each paper. The papers were grouped accordingly into five sections: Prevalence of Gender-Based Violence (GBV), social and cultural effects, impact on identity and psychological effects. Physical effects emerged as a particularly prominent theme however due to the large scope of this area it was not possible to explore this in detail, it is however highlighted throughout the review. Twenty three articles were identified through the selection procedures.

## **1.4 Conceptualising Gender Based Violence**

### *1.4.1 Violence in the context of war and conflict*

The 20th century was one of the most violent periods in human history with an estimated 191 million people losing their lives directly or indirectly as a result of conflict (Rummel, 1994). Besides the thousands killed each year, many more are injured or disabled (WHO, 2002). It is often viewed as an inevitable part of life and something to respond to rather than prevent. However, these assumptions are now changing and the health sector has both a special interest and key role in preventing violence (WHO, 2002).

It is argued by UNIFEM (2003) that victims of armed conflict are more likely to be civilians than soldiers, this is supported by Renzetti (2005) who claimed that around 70% of casualties in recent wars were non combatants, and most of these were women and children. However, combatants are at increased exposure during armed conflict and Johnson et al., (2008) have argued that they are at a higher risk of mental health problems such as depression and symptoms of Post Traumatic Stress Disorder.

### *1.4.2. Sexual Violence*

Sexual violence is experienced by both men and women during conflict. It is more frequently documented in women during war and includes; rape and gang rapes, forced pregnancies, genital mutilation, forced prostitution and sexual slavery (Liebling, 2004). Women are a target for specific forms of violence based on their gender, and are increasingly survivors of sexual violence in war situations (Jansen,

2006; Liebling-Kalifani et al., 2007; 2008; 2009; Rehn and Sirleaf, 2002). While there is substantial literature on women, in contrast the literature on sexual violence against men is scarce, possibly due to stigma and underreporting (Henttonen, Watts, Roberts, Kaducu and Borchert, 2008).

Sexual violence has historically been used as method of torture during conflict, for example in 1800 when Scottish women were raped during the English occupation. Rape has also been used as a method of torture in Korea during World War II, Bangladesh during the War of Independence and conflicts in Algeria, Indonesia, Liberia, Rwanda, Uganda and the former Yugoslavia (WHO, 2002). Soldiers rape the wives, mothers, daughters and sisters of their opponents as acts of humiliation and revenge against the enemy as a whole. For example the estimated number of women in Bosnia and Herzegovina raped by soldiers during the Bosnian War over a five month period in 1992 ranged from 10,000 to 60,000.

Alarming in 1994 during the genocide in Rwanda, UNIFEM (2003) estimated that over 500,000 women were raped and mutilated; a high proportion of these women now live with HIV/AIDS. In the Congo, where more than three million people have been displaced by war, the human rights group Amnesty International (2005) reported that 40,000 cases of rape had been reported over the previous six years. However, this is likely to be an incomplete count as the humanitarian and international organisations compiling the figures have limited access to conflict areas and only women who have reported for treatment are included (Amnesty International, 2005).



Musisi, Kinyanda, Liebling and Kiziri-Mayengo (2000) in the context of Uganda, argue that rape is the second most common form of torture during conflict, supporting a widely accepted notion that women's bodies are being used as battlegrounds over which opposing forces struggle (Jansen, 2006). Women's bodies hold significant symbolic meaning during conflict. Sideris (2003) argues that 'a large measure of the social value women have derives from their capacity to bear children' (Sideris, 2003, p. 721). Damage to reproductive organs renders them infertile therefore stripping women of their self worth. Men, particularly within an African context judge the value of their wives by their capacity to conceive and bear children and many women are punished or rejected for not conceiving. This theory is supported by several researchers including Donovan, (2002); Amnesty International, (2005); Liebling-Kalifani, (2007) and Rehn and Sirleaf, (2002).

The act of rape is used in order to wipe out communities and particular ethnic groups. Salzman (1998) reports evidence of systematic 'ethnic cleansing' in the former Yugoslavia where impregnation of women appeared to follow the discourse that ethnicity is determined by the father rather than the mother. The concept of ethnic cleansing is further supported in Rwanda where rape was used as a way of wiping out the Tutsis, this was eventually ruled as an act of genocide by a international criminal tribunal (Refugee Council, 2009). Kelly (2000, p.50) argues that women's bodies are 'constructed as territory to be conquered' and 'vehicles through which the nation/group can be reproduced'.

The term sexual and gender based violence (GBV) in its widest sense, refers to the physical, emotional or sexual abuse of a survivor (Rumbold, 2008). GBV has been

utilised as an umbrella term to conceptualise and understand violence that is specifically targeted towards men and women due to their gender. It is beyond the scope of this literature review to cover all areas of GBV, however it will focus on sexual violence and draw on other forms of GBV to highlight men and women's experiences where appropriate. The term 'gender-based' is used because violence is shaped by gender roles and status in society (Russo and Pirlott, 2006).

It is believed that women and girls make up the majority of survivors of GBV and therefore the United Nations (UN) has defined this term as:

Any act that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

(United Nations, 1995, D.112).

This definition implies that women are exclusively the victims of GBV. However Carpenter (2006) argues that although men are most often the perpetrators of rape and violence during armed conflict, it should be acknowledged that they too can also be subject to rape and sexual abuse (Moser and Clark, 2001). The Human Rights Watch (2002) argue for a more inclusive definition and state that:

Gender based violence is violence directed at an individual, male or female, based on his or her specific gender role in society.

(Human Rights Watch, 2002, p.8).

Research into the effects of gender-based violence has argued it is a global health and development issue (UN, 1995). Understanding gender-based violence and its

sequelae provides an insight into the differential content and consequences of large scale violence for men and women.

El-Bushra (2000, p.66) states that 'gender' is the 'socially constructed differences between men and women', i.e. the social construction of masculinity and femininity. Hague (1997) supports this in the context of Bosnia Herzegovina arguing that rape is an alliance of masculine sexuality's aggressive, violent and dominating position with respect to femininity's allegedly inherent passivity.

#### *1.4.3. Prevalence of Gender-Based Violence*

Researching and documenting gender-based violence is extremely challenging due to the complex ethical issues and surrounding safety. It is therefore difficult to obtain reliable and accurate numbers about gender-based violence, especially sexual violence (Refugee Council, 2009).

Johnson et al., (2008) investigated the prevalence and impact of war related trauma amongst Liberian combatants and non-combatants. They found that female combatants had a higher exposure to sexual violence (42.3%) compared to men (32.6%). Interestingly, in their sample of non combatants, women again were at increased risk of sexual violence however figures for women and men were relatively low (9.2% and 7.4% respectively). Results suggest that women experience sexual violence more than men and this is more prevalent in combatants than non-combatants. It is noticeable here that 'combatants' in this study included women who had been abducted by soldiers and forced to be cooks, domestic labourers and porters and does not necessarily mean women on the front line fighting. Low incidence rates of sexual violence among civilians in the Johnson et al., study are supported by

Amowitz et al., (2002) who found prevalence rates of 8% in women living in Internally Displaced Camps (IDCs) in Sierra Leone.

It is worth drawing attention to the fact that these are *reported* cases. There is huge stigma surrounding sexual violence and authors have argued that possible reasons for low prevalence rates could be due to underreporting; sexual violence is a particularly sensitive topic particularly within African societies and therefore often very difficult to talk about (Liebling and Shah, 2001; 2002). Most rape survivors worldwide never disclose their experiences, of those few who speak out, only a small fraction report the incident to the police or legal authorities. Researchers have argued that reasons for this under-reporting include fear of retaliation, prevailing social attitudes that blame the victim, social stigma, and limited recourse for justice as well as possible psychological consequences of disclosure. (Liebling-Kalifani et al., 2008; Sideris, 2003).

Isis-Women's International Cross Cultural Exchange (Isis-WICCE) is an international women's non-governmental organisation based in Kampala, Uganda, which was set up to disseminate information and campaign to overcome gender inequalities all over the world. In a study carried out in Kitgum, northern Uganda, Isis- WICCE (2006a) reported a much higher occurrence of sexual assault. 25% of the women interviewed reported being subjected to various forms of sexual torture and almost 20% described violent penetrative sexual abuse including rape, gang rape and defilement. In addition, 14.6% suffered sexual abuse including incest, sexual slavery and forced marriages. These higher incidence rates support findings in the Luwero district of Uganda, where a study carried out by Isis-WICCE (1998) found that 54.4% of women reportedly suffered sexual violence during the war between

1981 and 1986. However Lubanga (1998) who found that 88% of respondents knew someone who had been sexually abused estimated that the prevalence is likely to be between 50 and 70%. As a result of rape HIV and AIDS are also widespread leaving scars and painful reminders of the war (Isis-WICCE, 1998).

Swiss et al., (1998) documented women's experiences of violence by soldiers during the fourteen year war in Liberia. This study showed a 49% prevalence rate, however this figure was for the combined prevalence of both physical and sexual violence. The actual rate of sexual assault on women was 15% which although is a higher prevalence than that found by some (Johnson et al., 2008; Amowitz et al., 2002), it is actually relatively low compared to the studies carried out by Isis-WICCE (1998; 2006). The varying prevalence rates of GBV highlighted here illustrates the difficulties in obtaining accurate figures.

Establishing a trusting relationship between the researcher and participant when discussing sensitive issues is paramount and it may be that some researchers were not known to participants. Isis-WICCE reportedly spent two years building up trust with women in the communities of the Luwero district before women 'spoke out' to researchers about their experiences of rape and torture (Liebling and Shah, 2001). This may explain higher prevalence rates in their research because their participants are likely to have built up trusting relationships with researchers and may have felt safer to disclose their experiences.

Swiss et al., (1998) and Amowitz et al., (2002) documented women's experiences of violence perpetrated by soldiers or fighters and did not address violence perpetrated

by civilians, therefore the study did not reflect all incidents of sexual violence during war. Equally, with the exception of Johnson et al., (2008) most of the studies reviewed relied on samples taken from a subset of the population - usually less than three counties and therefore yielded estimates that were not necessarily representative of the entire country. Actual rates are likely to be much higher.

The term 'combatant' appears slightly ambiguous and somewhat misleading in the literature as it includes women who are forced into becoming slaves for soldiers in some studies who are seen as 'civilians' or 'non combatants' in others. This needs to be made clearer as it may skew results leading to inaccurate reporting. It is clear however that sexual/GBV violence is widespread among women and recent evidence suggests their increased vulnerability over recent years (Liebling-Kalifani et al., 2007; Isis-WICCE, 1998; 2006a). As pointed out by Okazawa-Rey:

Most casualties of modern high-tech warfare are civilians, especially women and children who constitute the majority of those in refugee camps.  
(Okazawa-Rey, 2002, p. 373).

The United Nations High Commissioner for Refugees (UNHCR, 2001) argues that, the majority of the victims of sexual violence are women and girls who live in camps for internally displaced people (IDP). They reported in 2007 that there were 11.4 million refugees outside their countries and 26 million IDP's as a result of conflict or persecution (UNHCR, 2007). A remarkable 80% of the population were women and children highlighting displacement as a major vulnerability factor for women compared to men who tend to be more actively involved in the military groups. Women and children are forced to flee their homes and walk for days to nearest refugee camps, once they have found apparent security or respite in these camps,

there are many accounts of further rape and maltreatment (Liebling-Kalifani et al., 2008). Most of the rapes and attacks take place when victims are outside the confines of the IDP camps, in a refugee camp in Darfur for instance, up to sixteen women were raped every day whilst collecting water from the river (Amnesty International, 2004). In these contexts Kelly (2000) argues that the hardships women experience on the way to IDP camps are clearly as physically and mentally wearing as the experiences of men. Even during times of peacekeeping there is an association between the arrival of peacekeeping personnel and increased prostitution, HIV/AIDS and sexual exploitation (Rehn and Sirleaf, 2002). The research demonstrates that development and aid can worsen the gendered effects of war. Rehn and Sirleaf (2002) document incidences in the Democratic Republic of Congo (DRC) where peacekeepers were buying sex from young girls and that condoms were visibly scattered in field near UN compounds.

Men can be indirect targets of violence against women. Raping and 'dishonouring' women has been argued to be a way of 'violating and demoralising men' (Bennett et al., 1995). Women are perceived to be the preservers of family honour, and often symbolise a nation's racial purity and culture. The abuse and torture of female members of a man's family in front of him is used to convey the message that he has 'failed in his role as protector' (UN, 2002, p.16) and represents an attack on the entire country.

#### *1.4.4 Men's Experiences of Gender Based Violence.*

As previously highlighted gender-based violence has been framed principally with respect to violence against women and girls, particularly sexual violence. In the

literature GBV is regarded as predominantly men's violence towards women (UNHCR, 2001). However, men too can also suffer from GBV including sexual violence and research is increasingly challenging the view that it is confined to women. Carpenter (2006) challenges the notion that women and girls are the primary targets of GBV by arguing that it is impossible to confirm this without comparable data on the victimisation of men and boys. He argues that abuse of men both physically and sexually are endemic, particularly during war and can be conceptualized as GBV.

Research suggests that men are most likely to be targeted for physical violence and torture during armed conflict and make up the majority of casualties caused by small arms and light weapons (Liebling, 2004). More often than women, men are assumed to be potential combatants and are therefore treated by armed forces as though they are legitimate targets of political violence (Carpenter, 2006). It could be argued that these patterns of 'sex-selective' violence are gender-based because they are rooted in assumptions about male wartime roles - assumptions that both reflect and reproduce gender hierarchies prevalent in both peacetime and war (Carpenter, 2006).

In contrast it could be disputed that sex-selective killings of men is not gender-based and that men are in fact more likely than women to take up arms. However as pointed out by Wood (2004) women, like men can join armies and resistance groups and can also be responsible for atrocities. Wood illustrates this with the case of Pauline Nyiramasuhuko, Rwanda's former minister of women's affairs who allegedly used her official capacity in inciting Hutus to rape thousands of female Tutsis during the Genocide in 1994. Despite this, it is assumptions of gender that



account for this pattern of violence and even where women may be accountable men have continued to be predominantly targeted.

There is an assumption that adult men eagerly participate in hostilities however Wilmer (2002) points out that approximately 700,000 people fled to avoid conscription during the conflict in the former Yugoslavia and over 9000 charges of desertion were initiated in 1992 alone. In countries where men are prosecuted for fleeing conscription, penalties can vary from fines to death penalties and prison sentences which carry with it a risk of sexual violence in prisons (Human Rights Watch, 2001). In Iraq, desertion was so common after the 1991 Gulf War that the Hussein regime implemented a policy of mutilating captured deserters by removing ears, feet or hands in hospitals (Gendercide Watch, 2002).

Carpenter (2006) states that involuntary recruits are forced into military service through both actual and threatened violence which should be condemned by governments and recognised as GBV against men. 'Forced recruitment' is arguably sex-selective; although women can and do join the military men are typically targeted over women and girls. Equally, forced recruitment is justified by collectively held assumptions about masculine identity nationalism and militarism. Men are seen as able-bodied adults and protectors of 'weak defenceless women'. These gendered hierarchies force men into military service where they are perceived as a threat which invites sex-selective patterns of atrocity not only against those in the forces but also against the men who manage to remain in civilian sector.

Sexual violence has been acknowledged in men during wartime and Carlson (2006) recognised that sexual torture in men is most likely to take place in prison camps during armed conflict. Reports of sexual torture in the former Yugoslavia were so

frequent, he concluded that sexual assault against men including soldiers, prisoners and non-combatants, was perhaps not only widespread in war but that it was almost 'an integral part of war making itself' (Carlson, 2006, p.16).

In Bosnia Herzegovina for example, men were castrated and circumcised and prisoners were forced to perform sexual acts on guards and become sexual servants. Similarly men were forced at gun point to rape female family members (Bassiouni 1994). Sexual abuse of men along with the rape of the 'enemies' women are symbolic and arguably a gendered form of violence, which aims to feminise and therefore humiliate and shame men. It could be argued that only those who are 'passive' partners of sexual violence are the victims and that perpetrators cannot be seen in this light, however gendered constructions of a man as protector of his family are completely undermined in these situations resulting in psychological distress and destroyed identities (Carpenter, 2006).

As highlighted, men can be targeted for violence based on their gender and can suffer human rights abuses that are different from though equally unjust to those afflicting women. They are directly targeted in armed conflicts and the increasing number of households headed by women in conflict zones is an illustration of men's specific vulnerability (El Jack, 2002). Perhaps as with women, the reason for low numbers of reported cases in studies is due to stigma which may be particularly apparent in men who are socially constructed as 'strong' and 'powerful'. Admitting to sexual torture may further demoralise men but equally, the fact there are so few studies could equally reflect societies discomfort of sexual torture of men. It is

clearly a taboo subject and more evidence is needed to document men's experiences so that adequate services can be developed to help these silent survivors.

## **1.5 The Psychological and Social Impact of Gender-Based Violence**

Gender-based violence affects women and men in a myriad of ways both psychologically and physically. GBV against women in particular results in severe sexual and reproductive damage. Women can be infected with sexually transmitted diseases, HIV/AIDS and left with serious reproductive and gynaecological health problems (Liebling-Kalifani et al., 2008; McGinn, 2000; Brittain, 2003). Whilst it is beyond the scope of the current review, it is important to recognise that physical effects of GBV cause profound psychological problems among women.

### *1.5.1 Social and Cultural Impact.*

Social norms and cultural beliefs have a huge impact on the wellbeing of men and women following war, and are deeply enmeshed with psychological health and identity (Summerfield, 1995; 2000). People's social and cultural foundations, which provide them with inner stability and a sense of security are broken down during war (Sideris, 2003; Summerfield, 1995; 2000). For example in Mozambique sons killed fathers, children raped mothers and the dead were left unburied. This inversion of social norms and perversion of accepted values constitute deconstruction of the social order that undermines a coherent sense of life and meaning, which Sideris (2003) argues is in itself a traumatic experience.

The social impact of sexual violence, particularly for women has immense repercussions. For instance Gratton (2008) explored attitudes towards sexual

violence in people from the Democratic Republic of Congo. Nine members of a Congolese refugee community organisation were interviewed and discourses were identified which regarded women as 'destroyed,' 'worthless' and labelled as a 'prostitute'. This study draws attention to cultural beliefs that a women's value is determined by sexual worth which is equivalent to family honour. This is further supported by Sideris (2003) who examined how social context frames psychological responses to violent social conflict. Testimonies in women from Mozambique revealed beliefs that a woman whose sexual purity is spoiled brings dishonour to the family. As a result women are blamed for assaults and are seen as having been defiled (Burnett, 2002). Women may no longer be accepted by their families or communities and are forced to face their trauma alone; the stigma of having been raped forces them into silence.

In contrast Gratton (2008) found that male survivors of rape can also be perceived as being complicit in the act and are therefore labelled as 'homosexual'. Interestingly, the same study revealed beliefs that viewed male rape as if it were a group of men 'play fighting,' therefore understating sexual violence in men. Gratton's study highlights the differential prevailing social attitudes towards sexual violence for men and women. Women are positioned to feel deep shame and responsibility whereas men feel their identity as heterosexual males is undermined. Although there has been very little research on the psycho-social reactions of men to sexual violence, Carpenter (2006) argues that it is likely that such acts are deeply humiliating, and violate the sanctity of family relationships and other cultural norms.

Cultural beliefs highlighted in Gratton's study could reflect a reluctance to accept sexual violence in men, however such attitudes could be further adding to the stigma,

discouraging men to seek appropriate help. Male participants reported that most men who have been raped will then rape others to 're-masculinise' themselves, this may be because they do not have any other means of support in processing their trauma. The stigma of sexual violence and its effects is still a largely under researched area. Many women bear children from the rapes they endure which Nordstrom (1993) argues can evoke immense distress and conflict within families and the wider community. Cultural values and social attitudes particularly in African countries where the norm is for children to trace their descent through the father can further add to the social exclusion of mothers and children born out of rape (Sideris, 2003). Religious beliefs prevent some women from seeking abortion and they are often forced to abandon their babies for fear of social rejection. Liebling-Kalifani et al., (2008) reported 87.3% of women had not sought medical treatment from a qualified professional due to social factors; women did not speak out for fear of being socially rejected. 'Secrecy', Gratton (2008) argues is likely to be a protective factor.

Schweitzer et al., (2006) highlights the importance of social cohesiveness following war trauma and suggests that distress continues even after conflict has ended. They explored the impact of post-migration living difficulties and social support on the mental health of 63 Sudanese refugees. They found that perceived social support, particularly from family and immediate communities play a significant role in predicting mental health outcomes. It would follow therefore that being rejected by a family or community could have a devastating impact on people's ability to recover from GBV. Schweitzer et al., (2006) go on to argue that cultural systems are disrupted by separation from family and ethnic communities, this is particularly so in African contexts where there are large cultural differences and community bonds are

strong compared to many western communities. Refugees entering a new country may find that their sense of identity and belonging is challenged. It would follow therefore that social cohesiveness plays a significant part in restructuring social identity and reducing associated psychological distress. Eisenbruch (1991) supports this by arguing that a person's self concept and sense of meaning in life emerges from interactions and identification with family and cultural systems. This is also in agreement with Bracken et al., (1995) who reported that women in Uganda viewed community cohesiveness as an important factor in recovery.

### *1.5.2 Psychological Effects*

It is not surprising that psychological difficulties are common affecting between a third and half of war survivors (WHO, 2005). The World Health Organisation (2005, p. 2) urged 'support for implementation of programmes to repair the psychological damage of war and conflict'. Their report recognises that the majority of people suffering from mental health difficulties following war live in developing countries where capacity to take care of these problems is extremely limited.

The most frequently used western medical diagnosis for psychologically affected war survivors is post-traumatic stress disorder (PTSD), often with depressive or anxiety disorders. However, much of the literature has argued that most individuals report psychological symptoms that do not necessarily amount to disorders (Summerfield, 1995; Isis-WICCE, 2001, 2002, 2006; Schweitzer, 2006).

In a study by Liebling-Kalifani et al., (2007) in the Luwero district of Uganda, 54.2% of the women interviewed about their experiences of war had symptoms of post traumatic stress disorder. This is supported in another study by the same author

who found that symptoms of PTSD were high among women, particularly intrusive memories which were reported in 95.5% of women interviewed, and flashbacks/frightening images in 65.4% of respondents. Interestingly, these symptoms were prevalent 13 years after the civil war had ended, highlighting the long term effects in war survivors (Liebling-Kalifani and Kiziri-Mayengo, 2002). These long-term findings are supported by Carlsson and Kastrup, (2005) who found no changes in psychological symptoms or health related quality of life among Middle Eastern refugees. However, this study examined participants after only nine months, a much shorter time span than Liebling-Kalifani and Kiziri-Mayengo (2002).

Other studies however have highlighted psychological distress that doesn't necessarily meet criteria for PTSD. In 2008 for example, Liebling-Kalifani commented on studies carried out by Isis WICCE (2001a; 2002a; 2006a; 2006b) in northern Uganda who found that although 77% of women living in Gulu were found to experience psychological distress, only 39.9% met the criteria for PTSD. Similarly in Kitgum, Isis-WICCE (2006a) found that 69.4% of women and 60.9% of men experienced psychological distress however only 23.2% had a diagnosis of PTSD. Schweitzer et al., (2006) found that 25% of a Sudanese population reported clinically high levels of psychological distress however less than 5% met criteria for posttraumatic stress disorder. It should be acknowledged that prevalence's of PTSD in these studies are still considerably high however, in agreement with Summerfield (1995), the research highlights how western models of PTSD may not necessarily be appropriate for explaining survivors' symptoms of psychological distress. This is further supported by Liebling-Kalifani (in press) who argues for an alternative

conceptualisation of trauma as a deconstruction of identity. In the context of Luwero, Uganda, she goes on to state that:

PTSD as a concept is not gendered and does not account for the realities, experiences and effects described by men and women. Nor can it explain the continuous and long-term traumatising evident.

(Liebling-Kalifani, in press. p.15).

Interestingly somatoform disorders are also common among men and women, for instance Isis-WICCE (2001a) found a prevalence rate of 72.7% reflecting the idea that physical symptoms may be cultural expressions of emotional distress (Bracken, 1995). Such symptoms can include; headaches, ulcers, hernias and loss of appetite (Liebling-Kalifani and Kiziri-Mayengo, 2002). In addition to this Somasundaram and Sivayokan (1994) found symptoms of PTSD in only 23% of participants with other psychiatric disorders such as somatisation being more common (41%).

Schweitzer et al., (2006) found increases in somatisation as well as anxiety and depression amongst refugees attempting to adjust to a new life in Australia. They argue that this could reflect psychological distress associated with the loss of identity in a culturally alien environment. People flee their countries to escape the trauma of war, however social isolation, poverty, hostility, discrimination, loss of status and racism in recipient countries may have a compounding negative effect on psychological health. The uncertainty of a life in limbo and the fear of being sent home may dominate the lives of refugees (Burnett, 2002).

Research has not universally agreed that men or women suffer greater psychological distress during and following conflict. Most research suggests that mental health difficulties are higher amongst women (Isis- WICCE, 2001a; 2006a; Schweitzer et



al., 2006). However Isis-WICCE (2002a) found no significant differences in levels of psychological distress among men and women. Research has argued that any differences between men and women perhaps lie in their coping strategies. Isis-WICCE (2006a) identified clear differences in how distress is expressed, with women expressing more suicidal ideation whilst men reported more problems with alcohol misuse and completed suicides. These gender differences are also reflected by Johnson et al., (2008) who also found that 12% of men compared to 2% of women reported drug misuse. This is further addressed by El-Bushra (2000) who argues that men can be left with an eroded sense of manhood and 'drink to forget how helpless they have become with the loss of their homes cattle and privacy' (El-Bushra, 2000, p. 68). Furthermore men's increased drinking and drug taking may further alienate women and result in increases in domestic violence (El-Bushra, 2000). Difficulties in identifying differences in psychological distress may be due to the fact that men and women experience, make sense of and are affected by GBV in different ways.

Coping and resilience in victims of GBV is not adequately addressed in the literature and Liebling-Kalifani and Kiziri-Mayengo (2002) comment that despite having high occurrences of trauma symptoms women in Uganda continue to develop ways of coping. This is echoed by Summerfield (1995) who argues that survivors are anything but psychiatric casualties and that they are active in maintaining their social world. Although there are significant psychological effects that can be understood within a PTSD framework this is disputed by many as being primarily a western concept (Summerfield, 1995; 2000; Bracken et al., 1995; Silove, 1999; Liebling-Kalifani and Kiziri-Mayengo, 2002). Previous research has proposed alternative

conceptualisations of trauma, for example as a deconstruction of identity (Liebling-Kalifani, in press) and ideas that encompass a more psycho-social view of mental health (Summerfield, 1995).

War trauma is said to be gendered whereas PTSD is arguably not (Liebling-Kalifani, 2007; 2008; in press) and cannot adequately account for social and cultural reality (Bracken 1998). Furthermore by giving a label of PTSD this may be undermining war survivors' capacity to recover within their own cultural framework.

A lack of understanding of culture can result in an oversight of mental health problems. Summerfield (1995; 2000) argues that symptoms of PTSD do not necessarily mean the same thing in different cultural and social settings. For example, recurrent nightmares for some sufferers may indicate a need to visit a mental health professional in western cultures however in eastern cultures they may represent a helpful message from his or her ancestors. Summerfield (1995) goes on to argue that the diagnosis of PTSD is made too often with war survivors and has been invented based on socio-political needs. He maintains this 'medicalisation' of distress turns normal grief reactions into medical problems and assumes a universally valid and applicable model.

Eisenbruch (1991) argues that the term 'Cultural Bereavement' - a grieving for home, language or traditions gives a more inclusive meaning to refugee's distress than PTSD. Based on his research with Cambodian refugees he argues that it encapsulates what the trauma means to survivors as well as cultural recipes for signalling distress and cultural strategies for overcoming it. He concludes that it identifies people who have PTSD but whose condition is a sign of normal

constructive rehabilitation from traumatic experiences. This is supported by Liebling-Kalifani et al., who argue that:

war trauma is a 'normal reaction' and understood as a collective breakdown in cultural identity, manifested in psychological, social, cultural and physical effects, which are integrated and inseparable, not split between mind/body and society.

(Liebling-Kalifani et al., 2008).

### *1.5.3 Impact on Identity*

Gender-based violence destabilises the victim's sense of identity, agency and control (Silove, 1999) Oppressive regimes use sexual violence and other forms of physical violence to undermine the sense of cohesion and identity of individuals and communities. Silove (1999) argues that physical injury and mutilation, resulting disability and the anonymity of being forced into refugee camps may add to distortions in self concept and sense of identity having a significant impact on psychological wellbeing.

Research has suggested that women shape their identity within domestic life (Sideris, 2003; Brittain; 2003). Women are often the breadwinners of the family constituting the large majority of agricultural produce (Brittain, 2003). Severe physical problems as a result of sexual/GBV violence affects their ability to work and hence their identities as economic producers and providers for their families are damaged (Sideris, 2003). Women are forced to flee their homes and fields on which they work, this is particularly a problem in rural areas where many women are raped in their fields and are then afraid to go back (Doctors without Borders, 2004). For women this is more than just material loss, where they once took pride in being able to provide for their families they now suffer a loss of self-worth, dignity and

purpose; the effects represent an attack on personal and social identity (Brittain, 2003).

During war women are forced to take on increased responsibilities and often take on the role of head of the household, a role traditionally taken on by men. Frequently more men are killed in conflict leaving women to deal with family responsibilities, of those that do return they may be injured, disabled and rendered unemployable. Liebling-Kalifani (in press) argues in the context of Luwero, Uganda that men return home following war to find their role as protector of the family has been replaced by women. They do not have the moral authority to direct the family as they are unable to provide for them which is seen as a masculine quality, as a result their gender identity is challenged. The taking on of men's roles gives women relative independence from male authority. Women develop greater autonomy and responsibilities rather than being vulnerable and dependant, which can have an empowering affect increasing strength and resilience (Liebling-Kalifani, in press; Sideris, 2003). Men on the other hand may find it difficult to re-enter this newly constructed family unit and it has been reported that following war there can be increases in domestic violence (Rehn and Sirleaf, 2002). Silove (1999) argues that the inability to regain a sense of identity, agency and meaning in life can lead to feelings of helplessness, powerlessness and that these feelings can manifest in poor social functioning and symptoms of anxiety and depression.

## **1.6 Methodological limitations**

Research reviewed has a number of limitations not least of which is an over reliance on quantitative methodologies. Many of the studies relied on questionnaires and

checklists developed in western countries to measure psychological distress in participants. These measures pose a number of potential problems; firstly they are standardised for western cultures which, as the literature argues may result in a misunderstanding of the questions for participants from eastern cultures. Furthermore, questionnaires are likely to require translating which could cause further misinterpretation if not translated with the same meaning. Reliance on in vivo translation of questionnaires may introduce what Schweitzer (2006) terms 'transcultural errors' into response items.

Secondly, confining participants to 'tick boxes' or 'likert' scales does not allow for interpretation as more qualitative methods do. The rigidity of some screening tools such as those utilising a diagnosis of PTSD do not always allow for in depth exploration of social and cultural aspects. In the studies reviewed authors acknowledge the small sample sizes used in their research. Additionally samples are usually from a subset of a population e.g. small communities or villages and therefore cannot be representative of the country.

It is equally important to consider the limitations of utilising qualitative methodologies in this context. Unfamiliarity with the researcher/interviewer as well as gender, cultural and language barriers may serve to hinder responses from participants. Quantitative measures such as questionnaires are often able to offer a more confidential way of collecting information and are more likely to produce results that can be replicated and are more generalisable than some qualitative methods.

Whilst studies carried out in native villages can encourage participants to speak more freely in familiar environments it can also create practical complications when roads become inaccessible to participants and researchers are forced to use alternative more accessible villages to conduct studies (Johnson et al., 2008). Interviews may be interrupted producing incomplete interviews or participants may not attend follow up assessments. Such practicalities and unavoidable biases in using 'more convenient locations' can yield unreliable data and the lack of uniformity in the way data are collected makes it difficult to compare data across communities and nations.

Some studies fail to address the needs of survivors themselves. For instance, Gratton (2008) conducted her research with members of a community organisation who had *not* experienced GBV; future research could explore discourses amongst survivors themselves to find out how they view themselves following rape and how they feel they are perceived by others as a comparison.

## **1.7 Conclusions: Future Research and Clinical Implications**

The aims of this review were to begin to conceptualise and understand the differential effects of gender-based violence drawing on identity and socio-cultural aspects. The literature identified that the effects of war and conflict fought on different continents all over the world are painfully similar.

A review of the literature identified that there is growing evidence that war trauma can be understood as a breakdown of cultural identity manifested in physical, psychological and social effects that are intrinsically linked (Summerfield 1995; Liebling-Kalifani, 2007; 2009; In press). Disrupted cultural norms disturb social and

personal identity which in turn affects psychological wellbeing. Somatic and spirit injury are enmeshed and physical problems communicate social suffering. Men and women interpret different meanings from their experiences and can be differentially affected with women more frequently being exiled from their social environments leaving them isolated and further exacerbating psychological distress.

Lack of resources following war and limited attention to gender differences also hinders recovery process and enhances women's powerlessness making it difficult to seek justice. In the context of Luwero, Liebling-Kalifani et al., (2007) argued for legal redress for the human rights abuses women suffered, and proposed using group actions under international laws. Although legal justice is beyond the scope of this review, future research could highlight how legal processes could be improved, incorporated into studies about men and women's resilience and how it's linked to psychological recovery.

Both men and women's identities are affected by violence during war, either through damage from physical injury, or changes in gender roles, which can result in disempowerment for men yet, may empower women. Research needs to focus more on ways in which both women and men war survivors can be empowered and reconstruct their identities as this may help relieve psychological distress. Equally, this may have implications for mental health professionals in that treatment may focus more on building on resilience and reconstructing a sense of self rather than focussing on specific symptoms.

It would appear from the literature that women are more vulnerable to GBV than men however the distinct lack of literature on GBV in men makes this notion

difficult to critique with confidence. It is vital that more research is carried out exploring men's experiences as they seem to be a largely neglected yet considerably affected population. Very few studies acknowledge GBV in males and those that do fail to analyse these experiences in detail and tend illustrate men's experiences as a means of highlighting women's plight (Carpenter, 2006). The limited literature acknowledges that men too can be victims of sexual violence but fails to highlight other areas of GBV targeted specifically towards men.

Another aim of the literature review was to provide a critique of the use of the diagnosis of Post Traumatic Stress Disorder in war survivors. Whilst the literature highlights the importance of this model in terms of identifying and assisting understanding of some of the psychological impact of GBV on men and women, much of the literature reviewed argues that PTSD is not gendered and that understandings of trauma should include attention to gender and cultural issues. Few studies reviewed utilised a cultural framework and future research in non-western cultures needs to move away from using standardised PTSD questionnaires and encompass survivors' own interpretations of their experiences. As Eisenbruch (1991) has argued this may be more fully understood in the context of a 'cultural bereavement'.

One of the main reasons for underreporting of GBV is stigma. The literature indicates that stigma and shame particularly with respect to sexual violence in African contexts are a large deterrent for people accessing services. None of the studies reviewed explored this in detail and future research needs explore this in an attempt to inform health professionals how best to address it.



The research reviewed suggests that gender-based violence is highly prevalent all over the world. However data relies on *reported* cases and participants who actively seek help or who are referred to services. Almost all of the research reviewed failed to address in detail the fact that despite the trauma people from war torn countries experience these people go on to develop their own coping strategies and continue to rebuild their lives. Studies of people who do not seek help are also important and as such are underreported. Perhaps rather than addressing why or how individuals become psychologically unwell following war trauma, research needs to focus on how or why the majority of survivors do not (Summerfield, 2000).

In summary, the nature of violence carried out during war and its' affects are different in men and women. Although many researchers utilise the concept of PTSD for understanding the traumatic effects, it is argued here that the effects of women's experiences of GBV can be better understood within a socio-cultural framework. Despite a significant impact on health, women war survivors actively reconstruct their identities and demonstrate remarkable resilience. In contrast the literature suggests that men often turn to other methods of coping such as drug and alcohol abuse.

In addition to actual variations in the level of violence, there may be differences in research methods, definitions of violence, sampling techniques, interviewer training and skills, and cultural differences that affect willingness to reveal intimate experiences. Gender-based violence against women and men in armed conflict and post-conflict situations remains under documented (Refugee Council 2009). The prospect of improved data on 'war rape' is offered by Security Council Resolution 1820 (2008, p.4) which requires the UN Secretary General to produce regular global

reports on the use of sexual violence in armed conflict, the first by 30 June 2009 (Refugee Council, 2009).

Equally, the UN Security Council Resolution 1325 has called for governments to enact laws and resolutions which would assist the lives of women and men affected by war using a gendered approach. This includes policy recommendations to enhance empowerment, specialist psychosocial and reproductive health services and the reform of security, army and police. Further research could usefully evaluate the effective implementation of this.

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## **Chapter Two**

### **A Grounded Theory Investigation into the Experiences of African Women Refugees: Effects on Resilience and Identity and Implications for Service Provision.**

**Target Journal: Journal of international Women's Studies**

**See Appendix A for instructions for Authors**

**Word Count (Excluding abstract, tables, figures and references): 9237**

## **2.1 Abstract**

The current study aimed to explore African women's experiences of violence during conflict. It sought to identify the impact of violence on mental health as well as develop a greater understanding of the roles of resilience, coping and identity. Previous research on women refugee's experiences has focused on the negative impact on psychological functioning despite indications that they show great strength and resilience. Analysis of the results identified a relationship between resilience, access to rights and support and identity. It also recognised cultural and societal influences and experiences in the United Kingdom as contributing factors. Results from the study support the move toward a holistic model of understanding refugee women's experiences. However, the study also reveals the importance of support and treatment assisting women to utilise their resilience in reconstructing their identities from traumatic events and recovery process

## **2.2 Background Information**

### *2.2.1 Violence and Conflict*

The world has suffered a number of wars and conflicts over the last sixty years. Summerfield (1995) reports that there have been an estimated 150 wars in the developing world since 1945 which has left 22 million people dead. Despite this, relatively little is known about the patterns of distress and recovery following violence during conflict.

Some people remain in their native countries during and following war, however many others are forced to flee the violence and seek asylum in other parts of the world. There are currently around 32.9 million refugees worldwide known to the United Nations High Commissioner for Refugees (UNHCR) a 56% increase since 2005 (UNHCR, 2007). There are an estimated ten million refugees and a further twenty five million people internally displaced within their own countries separated from their homes and livelihoods, half of whom are not recognised by international laws.

Britain, as a signatory to the 1951 Geneva Convention has traditionally offered asylum to those fleeing from persecution and violence. Under the terms of the convention, a refugee is defined as any person who;

Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear is unwilling to return to it.

United Nations (1951, p.16)

In a report published by UNHCR in March 2009 it was reported that 30,500 applications for asylum were received in the United Kingdom in 2008, an increase of 8% from the previous year. This is however a reduction since its peak in 2002 when 103,000 people requested refugee status. 2008 saw a surge of applications made by refugees from African countries such as Somalia, Zimbabwe, Nigeria and Eritrea making it currently the second highest continent of origin for refugees entering the UK. This reflects the ongoing conflict within these countries (UNHCR, 2009).



Literature on the mental health of refugees has explored psychological distress immediately following war (Johnson et al., 2008; Rehn & Sirleaf, 2002; Jansen, 2006). However recent research has also drawn attention to the emotional distress experienced during transit and post-migration periods (Schweitzer, Greenslade & Kagee, 2007; Khawaja, White, Schweitzer & Greenslade, 2008). Schweitzer, Melville, Steel & Lacharez (2006) for example found that post-migration difficulties such as unemployment and family separation were associated with symptoms of depression and anxiety in 63 resettled Sudanese refugees.

Studies have highlighted the effects of war on physical and social wellbeing and has demonstrated how these effects are intrinsically bound up in psychological distress (Isis-WICCE, 2001a; 2002a; Liebling-Kalifani, 2007; 2009; in press). Historically this has been understood within a model of post traumatic stress however the strong focus on posttraumatic stress reactions, particularly within a biomedical model means that limited attention has been directed towards understanding positive adaptation in war survivors. This theoretical conceptualisation cannot explain the relatively low rates of psychiatric symptomatology in post-war societies (Silove, 2001). For example, Steel, Silove, Phan & Bauman (2002) found that only 3% of a sample of Vietnamese refugees living in Australia had developed PTSD. These findings support other studies in Sudan and Uganda (Schweitzer et al., 2006; Isis-WICCE, 2006a) and suggest that the majority of refugees successfully adapt to stressors and trauma. Another concern with research based on the biomedical model arises from its general reliance on quantitative methodologies (Silove, 2001). Much of the current research is based on the use of checklists and structured questionnaires, which fail to capture the diverse human experiences associated with

extreme events (Miller, Worthington, Muzurovic, Tipping & Goldman, 2002). Furthermore they work on a priori assumptions and overlook other factors associated with distress and coping in refugees such as a loss of identity or existential factors. Recognition of these limitations and other research design flaws has spurred a shift towards the use of more qualitative approaches.

### *2.2.2 Resilience and Recovery*

As previously mentioned and as argued by Linely & Joseph (2004), a substantial amount of research tends to focus on the negative sequelae of trauma and adversity, which can lead to a biased and western understanding of post traumatic reactions. In recent years a number of psychologists have turned their attention to positive human functioning and the question of how health professionals can help achieve a more optimal level of well being. This move towards positive psychology contrasts very much with the more traditional emphasis by psychologists on psychopathology. It is now recognised that large numbers of people manage to endure the temporary upheaval of loss or potentially traumatic events remarkably well, with no apparent disruption in their ability to function at work or in close relationships (Bonanno, 2004).

Christopher (2000) in her study on psychological health in Irish immigrants suggested that resilience results from a person's ability to make meaning out of a stressful situation and to activate internal resources to resolve stress-laden issues.

It appears that the concept of resilience has often been viewed as a pathological state or seen only in rare and exceptionally healthy individuals (Bonanno, 2004). Other available evidence suggests that resilience to violent and life threatening events is

actually quite common. For example, Hanson et al., (1995) found 78.2% of individuals exposed to the 1992 Los Angeles riots reported three or fewer PTSD symptoms. Similarly, in a study of PTSD among Gulf War veterans Sutker et al., (1995) found that the majority (62.5%) had no psychological distress when examined within one year of their return to the United States.

In a review, Bonanno (2004) states that resilience and recovery can be seen as the same which he argues can have detrimental effects on survivors. It would appear that recovery suggests a path whereby normal functioning temporarily gives way to symptoms of PTSD or depression, usually for a period of several months and then gradually returns to pre-event levels whereas resilience implies stability from the onset. Bonanno accuses practitioners of wrongly assuming that all individuals exposed to a violent or life threatening event could benefit from professional intervention. He goes on to say that failure to distinguish between recovery and resilience relates to current controversies about when and for whom clinical intervention might be appropriate and how in some cases intervention could actually be more harmful.

Similarly, Wessely (2005) argues that humans in general have a natural resilience in the face of adversity. He addresses the resilience of the people of London in the wake of the bombings in 2005, he pointed out that seconds after the attacks they were able to compose themselves and begin helping each other showing resilience at the onset. Survivors were immediately urged to take up psychological support however Wessely argued that in some cases this made people worse; that by talking to a professional discouraged survivors from accessing their own sources of

resilience and coping such as talking with family and friends or religious advisors.

He concluded with a need to:

Recognise resiliency and be careful to avoid shifting from the language of courage, resilience and well-earned pride in to the language of trauma and victimhood.

(Wessely, 2005, p. 550).

Fredrickson et al., (2003) draws on the concept of positive emotions and growth and suggests that these may help to build resilience. She identifies positive emotions amongst survivors in the wake of the September 11<sup>th</sup> attacks and acknowledges that at times positive emotions are an outcome of resilient coping however other evidence suggests that resilient people may also use positive emotions to achieve their effective coping such as humour (Masten, 1994) suggesting a reciprocal causality.

Tucker et al., (2002) similarly highlight a number of coping methods in body handlers after terrorism in Oklahoma in 1995. The most frequently reported means of coping were spending time with others and focusing on the positive. Other means included distraction, reframing – trying to see the good side of things, creating meaning and religious activities, such as attending memorial services and visiting bomb sites.

Positive growth refers to positive changes that can occur following traumatic events and it has been estimated that between 40% and 70% of people who experience a traumatic event later report some form of benefit from their experience. Indeed, Joseph et al., (2005) argue that some people even flourish. Linley & Joseph (2004) indicated that cognitive appraisal variables: threat, harm and controllability were

consistently associated with positive growth along with acceptance and positive reinterpretation, optimism, religion and positive affect. They also provided evidence for long-term effects citing a study by Frazier, Conlon & Glaser (2001) who showed at two weeks post-trauma, sexual assault survivors reported increased empathy and improved relationships. Positive changes in self and spirituality were generally established by two months following the event.

However, resilience and positive growth literature seldom cross reference one another, indeed Westphal & Bonanno (2007) even argue that resilient outcomes typically provide little need for growth. Implied in both however, is the idea that resilience is evident when an event has little or no psychological impact, presumably because the individual is able to access inner resources that existed pre-trauma, whereas positive growth is apparent following trauma in a higher level of functioning that has been pulled from a struggle to overcome the devastation of trauma. These distinctions blur, however as some studies highlight the ability of survivors to transform their experience post-trauma and other studies of positive growth confirm the relevance of attributes that clearly existed pre trauma (Linley & Joseph, 2004). It seems likely that some degree of resilience pre-trauma is requisite for posttraumatic growth, and that posttraumatic growth is in itself a sign of resilience.

The evidence reviewed suggests that resilience is common, is distinct from the process of recovery and can be potentially reached by a variety of pathways.

### *2.2.3 Resilience and Recovery in Refugees*

Interestingly, most existing research on resilience has taken place in the western world. Relatively few studies have addressed resilience and growth in war survivors and even fewer studies have addressed resilience in people from developing countries where support and opportunities for growth are limited.

Social and family support and cohesiveness has been reported to be a protective factor for refugees (Gorman, Brough and Ramirez, 2003). McMichael & Manderson (2004) found that social support from immediate and extended family members as well as the wider community can be associated with increased psychological wellbeing in refugees. This is supported by Schweitzer et al., (2006) and Jasinskaja-Lahti, Liebkind, Jaakkola & Reuter (2006). Similarly Almedom, Tesfamichael, Saeed, Mascie-Taylor & Alemu (2007) administered a sense of coherence scale to explore resilience among internally displaced and non-internally displaced Eritrean men and women. They found that displacement particularly in women war survivors compromised their resilience.

Religious beliefs and practices have also been shown to strengthen resilience particularly in African populations. For instance Halcon et al., (2004) found that between 50 and 75% of a sample of Somalian and Ethiopian refugee youths used prayer to relieve their sadness. Eisenbruch (1991) described what he termed 'culturally bereaved' Cambodians living in the United States who felt guilty about abandoning their homeland and about unfilled obligations to the dead. Haunted by painful memories they were unable to concentrate on tasks facing them in an alien society. He compares this group of refugees with young Cambodians living in

Australia who were under less pressure to conform and were given a chance to practice some traditional ceremonies, these refugees coped better than those in the United States. Religion and cultural beliefs can provide a meaningful framework in which to structure their suffering and continue to live their lives. Colic-Peisker & Tilbury (2003) propose that religious beliefs can in some cultures advocate a form of 'endurance' of current adversities with the belief that they will be rewarded with a better future.

Other forms of resilience and methods of coping among refugees lie in cognitive processes in the form of interpretations and perceptions of themselves and their situation (Khawaja et al., 2008). Such 'inner resources' include taking a positive approach, identifying strengths, reinforcing the determination to cope and self perception as a survivor rather than a victim (Gorman, et al., 2003). Goodman (2004) similarly highlights adaptive cognitive processing in refugee youths from Sudan such as giving new meaning to difficulties and talking about experiences, as well as emerging from hopelessness to hope and having aspirations for the future as a way of overcoming psychological problems.

Literature has highlighted how refugees, particularly women can be silenced due to huge stigma about their experiences during war and conflict. Consequently research has shown that giving women the opportunity to speak out about their experiences empowers them and strengthens their capacities to cope. Liebling-Kalifani (in press) found that women war survivors in Uganda who were speaking for the first time about their experiences of sexual violence found it helpful to narrate what had happened to them. Similarly Summerfield (1995) recognised that non-western

cultures have little place for the revelation of intimate and personal material outside the close family circle. He advocates the chance to be heard and believed in a safe place where expression of emotions and regeneration of hope fall on sympathetic ears.

Much of the research recognises the importance of human rights and working towards social justice and empowerment, as part of the recovery process for war survivors. Liebling-Kalifani et al., (2007) argued that human rights are an essential precondition for physical and mental health. In their paper looking at women's experiences during the war in the Luwero district of Uganda they recommended that to be successful:

Integrated health interventions for war torture survivors need to be combined with the further collective legal, social and political empowerment of women and address the health inequalities and discriminations that exist.

(Liebling-Kalifani et al., 2007, p.2)

Non-governmental organisations in some developing countries, aim to help men and women war survivors to rebuild their lives and empower them by becoming involved in income generating schemes and legal aid programmes. For example in Uganda, Liebling-Kalifani (2005) worked in collaboration with a non-governmental organisation called Isis Women's International Cross Cultural Exchange (Isis-WICCE) to promote women's roles in peace processes, which has assisted in their further empowerment and knowledge of their rights so that one day they maybe in a position to take action against some of the atrocities they experienced during the war.



#### *2.2.4 Summary*

Research has suggested that refugees who have experienced ongoing violence and atrocities for many years can show huge resilience in their survival and flight, being able to restructure their identities and continue to live their lives (Burnett, 2002; Liebling-Kalifani, 2007). The idea that people who have survived atrocities during wars are ‘survivors’ rather than ‘victims’ is now being considered more carefully (Bracken, 1997) and the use of a solely medical model is being increasingly challenged.

In recent research, authors have argued for a more ‘ecological’ view of resilience and coping in refugees which accounts for the direct and indirect influences of social and psychological factors (Harvey, 1996; Radan, 2007). It regards community values, beliefs, and traditions as pivotal influences on individual responses to and recovery from violence, abuse, and other traumatic events (Pratyusha, 2007; Haeri, 2007).

Mukta (2005) states that in order to build up resources of hope, we need to build on all ways in which people make sense of the violence, and the ways in which they reconstitute and reconstruct the fabric of their lives.

#### *2.2.5 Rationale for Study*

There is limited existing research exploring the resilience and coping strategies of refugees. Much of the literature has adopted quantitative methods, which rely on *a priori* assumptions about the range of relevant variables to be assessed. These assumptions can be problematic in this under-researched area where little is known about the phenomenon.

As highlighted in the literature most refugees in the world are women and children (UNHCR, 2009). They are vulnerable to gender-based discrimination, exploitation, and violence, and are at risk not only in the communities from which they are fleeing, but also in their adopted homelands and while en route from one to the other. As well, women endure the added difficulties of remaining responsible for the survival of their children and other members of their families, and for the preservation of their cultural heritage (Brautigan, 1996). They are often unable to call for help, press charges, or seek justice. Indeed, women can be killed if they try to resist or look to others for support. Thus, during war women face an ongoing catastrophe.

The present investigation aims to carry out an in-depth exploration of women refugees currently residing in the UK who have experienced violence in the context of war or political conflict. It will also address coping strategies used, which will further understanding on what assists women to recover from traumatic events. It employs a qualitative methodology so that the salient themes reflecting coping strategies will emerge from the data.

In addition this will provide useful clinical information which could be utilised to encourage mental health services in the UK to be more mindful of the existing pressures and available resources within this group and help professionals deliver a more culturally appropriate service.

The aims of the proposed study are in four thematic areas:

1. To explore the experiences of violence during conflict for African women refugees residing in the UK
2. To provide an understanding of the impact of violence on the mental health of African refugee women
3. To develop a greater understanding of the roles of resilience, coping and identity in African refugee women
4. To understand African refugee women's experiences in the UK and how this knowledge might be utilised to improve health service provision

## **2.3 Method**

An explorative, qualitative methodology was chosen to address the research aims allowing for an in-depth exploration of women's experiences and greater understanding of the impact of war on their mental health and resilience. Qualitative methodology also prioritises the views of participants as active agents constructing meaning from their own perspectives (Hood, Mayall & Oliver, 1999) which this research attempted to do.

As the current study aimed to explore in depth women's experiences, a grounded theory approach was considered to be the most appropriate methodology. Developed by Glaser and Strauss (1967) grounded theory is designed to facilitate the process of 'discovery' or theory generation (Willig, 2001). Rather than using data to test hypotheses derived from previous literature on a topic, grounded theory generates theory from data itself, usually verbal accounts of people's experiences. This ensures

that the researcher does not begin research with a pre-conceived theory in mind (Giles, 2002). Typically, data in grounded theory consists of transcribed interviews, data are then subjected to a continuous process of coding and categorizing known as 'constant comparative analysis' (Giles, 2002). By using grounded theory it is intended that this will more effectively illuminate the richness and diversity of their subjective experiences and will allow the researcher to explore these experiences and to develop a model based on analysis of this.

### *2.3.1 Ethical Approval*

Ethical approval was granted by Coventry University Ethics Committee (See Appendix 2a). Informed consent was obtained from the participants prior to taking part in the research (See Appendix 2b) Ethical conduct and confidentiality was adhered to as recommended by the British Psychological Society (2006). Due to the sensitive nature of the research it was possible that participants could become distressed during the interview. In the event of this happening, participants had been informed that the interview would stop. Participants were also aware that the interview could be stopped at any time during the interview and information could be destroyed should they wish. Participants were made aware of local support services and time was allowed at the end of the interviews to debrief participants and give them the opportunity to ask questions.

All information was kept confidential, anonymised and non-identifiable (BPS, 2006)

All data was stored on a password protected computer.

### *2.3.2 Participants*

The study comprised of a group of women African war survivors attending a refugee centre in the Midlands. Six volunteer participants were interviewed aged between 24-46 years. The length of time in the UK ranged from four years to six years and all women had been given at least five years leave to remain in the UK. 5 of the women were from Zimbabwe and 1 woman was from Somalia. The women from Zimbabwe followed a Christian faith and the woman from Somalia was Muslim. Women were approached and recruited through the refugee centre either individually or through the woman's group held at the centre, which ran on a weekly basis.

### *2.3.3 Interview Schedule*

A semi-structured interview schedule was developed to elicit participant's experiences based on the research aims (See Appendix 3) Through the use of open ended questions the researcher was able to ask questions that functioned as 'prompts' in order to encourage the participant to narrate their experiences and views. When devising the questions it was important that the researcher was familiar with the participants' cultural milieu so that the interview could be carried out in a manner that was culturally sensitive and had the same meanings and connotations for both interviewer and interviewee. This was addressed through pilot interviews which were also included in the analysis.

Although all participants were able to conduct the interview in English, interpreters at the Refugee Centre were available to aid participants in case their first language was not English. Care would have been taken to ensure the interpreters were as accurate as possible in their translations to encourage maximum validity and reliability of responses (Tribe and Ravel, 2003; Tribe, 2007).

#### *2.3.4 Procedure*

Details of the study were given to potential participants in the form of leaflets and information sheets (See Appendix 4). Information was distributed by key staff members, as well as by the researcher who was volunteering at the refugee centre as a caseworker for six months during data collection. Those who were interested provided the researcher with preferred contact details, the researcher then contacted participants and a mutually convenient time and date to meet was arranged. Interviews took place at the refugee centre and informed consent was sought before commencing. Interviews were recorded onto a digital recorder and lasted up to one hour with 10-15 minutes at the end for debriefing.

Following the interview participants were de-briefed and given the opportunity to ask any questions or discuss any concerns, they were also informed that for a limited time their data could be withdrawn from the study if they wished. Interviews were transcribed verbatim and data was coded to identify the participant to their transcript but coding was only known to the researcher so as not to breach confidentiality. All participants received £5 from the researcher to aid travel costs to and from their interview.

#### *2.3.5 Analysis*

Once the interviews had been transcribed each was analysed using the procedures of grounded theory as outlined by Strauss and Corbin (1990) and Giles (2002) with the aid of Atlas Ti, a computer software package. In the initial stages of the analysis open coding was used. This involves analysing each transcript and developing descriptive themes. Charmaz (2000) refers to this as 'line by line coding' although

not every line necessarily suggested a code. Once the initial set of codes were generated, these were integrated into broader conceptual categories.

Axial Coding was then established, which involved reducing the initial set of categories to an explanatory framework of 'higher order' categories by establishing links between them. Saturation of the codes was achieved when coding and categorizing of emerging themes reached a stage whereby no further evidence or contributions to the research could be made. The theory developed from the research was emergent directly from the interview data analysed. An example of a transcript of one of the interviews with initial line by line coding can be found in appendix 5.

### *2.3.6 Reliability and Validity*

Qualitative methods view reliability and validity as issues relating to accessing and representing the phenomena being studied. Validity is concerned with accurately identifying and understanding the experiences of the women in this study and reliability refers to the relative replicability of the interpretations made during the analysis and theory building process (Denzin & Lincoln, 2000). Theoretical memos were kept by the researcher to ensure the theory was grounded in the data. Validity checking was carried out between a research group of clinical psychology trainees who were familiar with the approach.

Hollway (1989) advocates the importance of subjectivity in the research process, it is therefore important to demonstrate this from the researcher's subjective viewpoint: In the current study I recognised the importance of my position and how any potential pre-existing assumptions may have influenced the interpretation of the data.

Whilst every effort was made to ensure the theory developed and analyses undertaken closely matched the data from the interviews, I recognised that my position as a trainee clinical psychologist and as a caseworker at the refugee centre may have had an influence on this process. For instance, my lack of knowledge about the asylum process may have meant that I did not appreciate the full impact of this experience for refugees. However, through working at the refugee centre I was able to develop a good knowledge of this complex process and additional stresses for refugees living in the UK. In addition it was important to acknowledge my position of being from a different culture and how a lack of understanding of African cultures may have also impacted on the process; my position of being an 'outsider' to the centre may have assisted refugees to develop or not develop trust during the interviews.

## **2.4 Results**

Following initial line by line coding, thirty three lower order categories were identified. These lower order categories were then grouped into broader conceptual categories producing seven higher order categories providing an explanatory framework for the emerging data (See table 1). Once no further codes were obtained and saturation of the data was reached, selective coding then enabled the development of a theory, which is represented visually in figure 1. This aims to aid understanding of the research findings and illustrate the relationship between categories.



**Table 1: Lower and Higher Order Categories.**

<b>Higher Order Categories</b>	<b>Lower Order Categories</b>
Experiences of War/Conflict	Witnessing violence/death Personal experiences of violence Loss of family member
Psychological Effects	Trauma symptoms Self Blame Anger Suicidal thoughts/behaviour
Cultural/Societal Influences	Going against culture Patriarchy of men Women's roles 'Inner struggle' Silenced
Resilience	Religion/faith Positive thinking Positive self talk Hope Problem solving
Access and Rights and Support	Justice Empowerment Practical help Opportunity Family/friends support Talking
Identity	Reconstruction/deconstruction Identity as a women Identity as a mother Independence Choice
Experiences in United Kingdom	Opportunity Choice Unfamiliarity Future Uncertainty

**Figure 1: A model to illustrate the Experiences of African Women Refugees in Africa: Effects on Resilience and Identity**

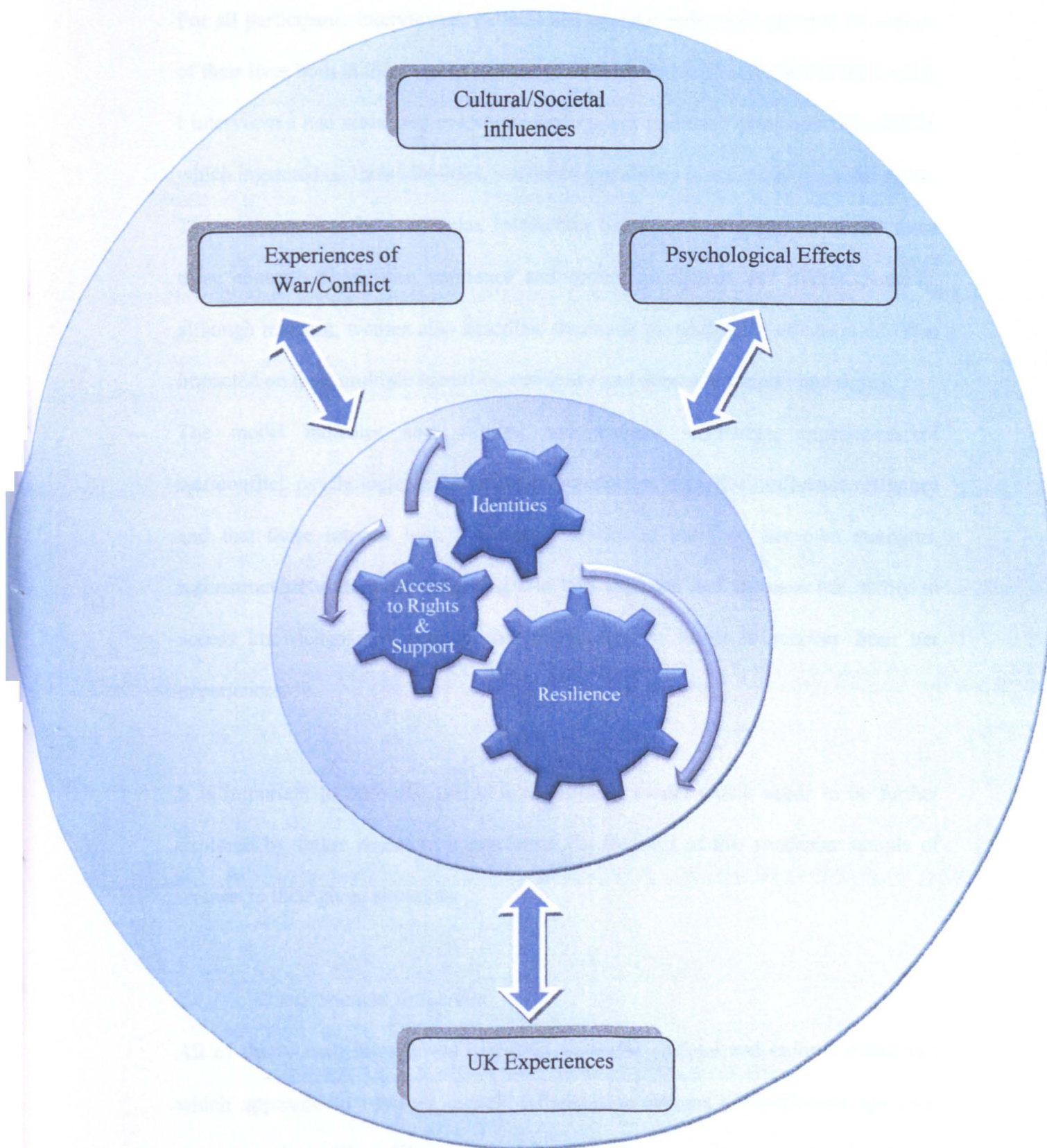


Figure one shows a model representing women participant's experiences of war violence in Africa and the interrelationship of their resilience and identities.

For all participants interviewed, cultural and societal influences affected all aspects of their lives both in their native countries in Africa and in the UK. All of the women I interviewed had witnessed or experienced violent traumatic events during conflict, which impacted on their identities, resilience and ability to access support and rights. There appeared to be a complex interaction between their experiences and these three concepts (Identities, resilience and access to support and rights). Notably, although resilient, women also described traumatic psychological effects which also impacted on their multiple identities, resilience and access to support and rights.

The model indicates how cultural and societal influences, experiences of war/conflict, psychological effects and experiences in the UK all influence resilience and that these interact with a woman's ability to build on her own strengths, reconstruct new identities following war and violence and increase her ability to access knowledge and support that allows her to begin to recover from her experiences.

It is important to note that this is a preliminary model which needs to be further explored by future research, it represents the findings of this particular sample of women in their given situations.

#### *2.4.1 Cultural/Societal Influences*

All of the women interviewed described powerful societal and cultural influences which appeared to have an overall influence on women's experiences and their capacity to be resilient. Women described an 'inferior' position in society in relation

to men, who were culturally regarded as being 'in control' of their women. One woman said:

*'Cos they have that you know that um ..... I don't know... that idea that idea that they are better than a woman they are always better than a woman everything you're supposed to do.... they have the last say and woman are just supposed to be underdogs'. (Participant 3, lines 293-295).*

Men's patriarchal roles often prevented women from seeking help as they were fearful of disclosing their experiences. One woman spoke of her experiences of domestic violence and how her family knew but chose to ignore what was going on telling her she should respect him regardless.

*'Yes. Nobody would come and try to stop him from doing what he's doing, that's how he was. You know they (parents) called me to say if you are in that sort of domestic, someone you respect, if someone comes you stop, just with that respect'. (Participant 6, lines 416-419).*

The strong cultural traditions of marriage and expectations of the family meant she was unable to leave the relationship leaving her feeling powerless and unable to speak out about experiences and seek support.

Women who had witnessed sexual violence described it as being a 'taboo' subject which meant that they were afraid to disclose their experiences for fear of being shunned by their family or community. One woman who had witnessed her sister being raped described her torment at being sworn to secrecy, she said:

*'You don't have to show any sign that something happened because if daddy's knows it's not good. I said, okay, and she said promise you'll say nothing'.*  
(Participant 2, lines 282-284).

Furthermore, one woman who had been diagnosed with HIV described feeling blamed by members of the community:

*'..... in Africa it's not custom to say something like that you know in Africa when you say HIV they think maybe you're selling your body something like that'.* (Participant 5, lines 195-196).

There appeared to be an inner struggle for women interviewed of wanting to seek help with their experiences yet fearing being shunned by their family or communities. This constant struggle meant that women felt 'trapped' which further decreased their capacity to cope rendering women isolated and psychologically affected. Those who did speak out were often accused of going against their culture and 'disrespecting their men'. Participant 3 said:

*'It was like.....you want to know too much, you're going against your culture. You're supposed to respect...you know... the men'.* (Participant 3, lines 275-276).

#### *2.4.2 Experiences*

All of the women interviewed described witnessing violence, sexual violence or death of a close relative as a result of conflict. One woman described as a child being

forced to watch her sister being raped by soldiers in the field where she was working, she said:

*'....and my sister was just not answering and they slapped her, and she was bleeding in her mouth because they slapped and they shove her, they pin her down. I was just standing there. They told me to stand there. Next to me there was another soldier standing next to me. My sister was crying and one of them, the one who was smacking her, put his hand on my sister's mouth. I didn't know what sex was, I didn't know then. But, yes, he raped my sister in front of me'. (Participant 2, lines 254-258).*

Another woman described the torture women endured:

*'Um... I witnessed women being beaten up and women... one time we did like a story of this woman erm.... in the villages it was worse in the villages she was beaten up like you say... the other party.... she was beaten up and she was raped and tortured and they put like erm.... you know plastics when you burn plastics.. Yeah yeah... It was like burning then they put it like on her breast'. (Participant 3, lines 181-183).*

Other women reported their own personal experiences of violence. One woman who was a member of an opposing political party described being kicked and beaten by police:

*'Him and two others were in this room and the guy was like... grabbing my hair and he was smoking and blowing it in my face and I'm asthmatic and he was blowing smoke in my face and all this it was horrible. You know for the*

*first time you know you really you are really thinking right this is it'.  
(Participant 6, lines 34-37).*

Although not all of the women had experienced violence directly, all women reported witnessing the death of at least one family member or loved one which, as one women said felt like it was happening to her:

*'It happened to me like ....the same because my mum and dad are like me I'm not happened to myself you know. It's happened in my blood'. (Participant 1, line 59).*

#### *2.4.3 Psychological Effects*

Women described a multitude of psychological effects following exposure to violence. Often the women felt they did not have access to support and were unable to discuss their feelings with anyone. Women described trauma symptoms following violence for example one woman said:

*'Sometimes when I'm sleeping I'm shocked and wake up crying I was sure it's happening No! to me something like that. I was shocked and sitting and crying and shouting then I sleep and there's nobody in here. Then I go back to sleep again'. (Participant 1, lines 151-154).*

Women described the emotional trauma of witnessing death and violence:

*'You could see dead bodies everything... yeah and then just seeing somebody being shot honestly ... I don't know how long it took me yeah I was just so*

*quietness speaking...not.. coz I was really shocked*'. (Participant 4, lines 254-255).

Those women who had no means of support often found that they turned their anger inwards and blamed themselves for what had happened, Women reported feeling shame:

*'If I saw someone I knew from Zimbabwe I couldn't look them in the face'*. (Participant 6, line 7).

Another woman reported feelings of anger and guilt about the murder of her parents, which reflected her powerlessness to seek justice or have any control over the situation:

*'I feel horrible, because ..... I feel horrible because, if you saw bleeding your mum. And Some people coming with no reason to kill, and you can't help them and is very horrible and shocked say if at the time I got the gun I will kill back them, something like that you feel like that because you feel guilty for your mum and your dad. Innocent doesn't do anything and it's killing straightaway with no reason to kill you feel angry I say you want be bigger or get something. Do that guy, who do it to your mum and your dad get you back something like that sometimes I feel guilty myself and crying you know'*. (Participant 1, lines 176 -183).



One woman even felt that dying would have been better than surviving her trauma:

*'You know, I used to feel like I don't care if I die. I think I'll have peace because from time to time I used to see it (Murder) happening again and again and again'. (Participant 2, lines 326-327).*

Psychological feelings were further exacerbated by the lack of support for women in Africa and gave them a sense of hopelessness.

#### *2.4.4 UK Experiences*

Despite the focus of the interview being on how women dealt with their experiences, women frequently reported how their experiences in the UK served to increase or decrease their strength and resilience and capacity to cope . Fear of being sent back to their country of origin and uncertainties about their future in the UK were mentioned by all women as well as being unable to work whilst waiting for asylum applications to process. One woman told me:

*'I'd heard of asylum and stuff but you just so afraid my biggest thing was fear I didn't even I thought if I can't claim what if they send me back and then I'm really really going to be in trouble coz failed asylum seekers when you go back that..... I know a family..... friends of family that have family that have gone back been deported back and nobody has seen them'. (Participant 6, lines 45-48).*

However, women reported having a better life in the UK once their security was established. They valued the *'freedom of being a human being'* (Participant 4, line

133) and being treated as equal which further reconstructed identity. One woman explained:

*'Hmm it's like as it is since I have come over here... yeah... and I have realized the changes yeah... the difference between where I came from and where am now really there are so many you know organizations that are helping out (excuse me) that are helping you know women to ...as we are doing right now.... yeah that just speak out'. (Participant 4, lines 203-205).*

Another woman said:

*'...because my life has changed you know what I am saying now because I am in this country'. (Participant 5, line 191).*

In contrast, one woman experienced the *'flip side of the coin'* (Participant 6, lines 73-74): her negative experiences in the UK resulted in her losing a sense of who she was. She reported feeling that she was unable to talk to anyone and felt depressed. She said:

*'My life has been a very big secret in the UK and that's not who I was....back in Africa'. (Participant 6, line 79).*

#### **2.4.5 Resilience**

Women were able to report a number of coping strategies that served to increase or decrease their inner strength and resilience. Women adopted positive thinking and self-talk as a way of getting through their distress by thinking of a positive future. One woman said:

*'There is a day... although you don't know when that better day is going to come but there is always hope that there's going to be a better day of my life, is going to be a little bit better than how it is now'. (Participant 2, lines 26-28).*

Another woman said:

*'.....my head, and I know it's coming like that. I was so young, and I say, look, if you think too much. You can be crazy. You can be having anything. And now you've lost all your family. If you loosen your mind there is problem. More problem... and be strong, and be good life, and then you stay alive you know?' (Participant 1, lines 49-53).*

Other women described taking positive action by problem solving:

*'I'll sit in that spot for bit and I'm like right now OK what do I do now OK ...this problem.... what am I going to do..... how am I gonna..... you know rather than dwelling it I jump out of the box'. (Participant 6, lines 201-203).*

All of the women valued religion immensely, and felt their faith was a major contributor to their resilience for instance one woman said:

*'...but who was I going to let it out to I didn't want people to know what I was going through or my situation so I go to God in prayer and that's where my strength came from'. (Participant 6, lines 143-144).*

Their firm beliefs allowed women to make sense of what was happening to them and allowed them to normalise their experiences:

*'You know, if Jesus went through all that, if he had the power to stop it and he didn't stop it just to show me how difficult life is, who is me to quiz? Who is me to quiz? With that I said, okay, I changed the whole situation'. (Participant 2, lines 362-364).*

Women described feeling empowered having come through their experiences and all had strong hopes for the future:

*'But I hope that one day things will be okay .....coz I've managed to pull it right through from back I am still hoping I will end up getting whatever I want'. (Participant 4, lines 187-188).*

#### *2.4.6 Access to Rights and Support*

Women reported feeling stronger and more resilient if they felt supported in rebuilding their lives. External agencies and practical help were valued although all the women reported that this help was only available to them since being in the UK. In this sense, support from families and friends were of particular value to the women living in Africa. One woman when asked if she felt family were a source of support replied:

*'Very very very much so I mean if you look here you have a brother a sister they all go out to fend for themselves if they can't they'll probably go to the Government. But in Africa you only got your family to lean on'. (Participant 6, lines 174-175).*

Equally, women described how they felt they got their strength from female members of their families. One woman spoke about her mother and said:

*'She was never negative always positive, even if we tell her that this thing you know is not right. But she is always putting us on the horizon'. (Participant 4, lines 175-176).*

Another woman described how talking to her family helped:

*'The only support you can have is like if you can talk to your sister or to your auntie about it, how you feel, that's the only counselling, you know'. (Participant 2, lines 504-505).*

Women felt that access to equal rights and justice was an important aspect of building their resilience and feeling empowered, and some of the women hoped to take legal action in the future, one woman told me:

*'Yeah, because the people had for example me, the people live who kill my family are still alive walking the streets I haven't passed them but they are still walking the streets. You feel guilty yourself. But if this person in prison your heart will be all right. Yeah in prison now he doesn't walk the streets'. (Participant 1, lines 40-44).*

Opportunities such as employment and education equally served to strengthen resilience and enable women to feel they had 'choice' and 'control' over their lives.

As participant one described:

*'I wanna be a nurse I wanna be a nurse, but my dreams (in Africa) were broken and it doesn't come true. Education is very very.... it starts life person starts life. ....it's very powerful you can do whatever you want no because my dream is being in school I liked school'.* (Participant 1, lines 69-73).

#### 2.4.7 Identity

Some women described feeling like they didn't have a sense of identity when living in Africa. Some of their experiences meant that they were forced to take on different roles and they described not knowing who they were *'the real me was lost'* (Participant 6, line 144). One women felt she was forced to adopt the identity of the opposing government party

*'They say that if you don't have a Zapu-pf card which means we are not Zimbabwean.....they were forcing us to be Zapu-pf'.* (Participant 5, lines 137-138).

Women valued their identity as a 'mother' and 'provider' reporting that it helped keep them strong and many reported staying resilient for the sake of their children. A woman who was in a violent relationship with a soldier reported:

*'I did my role as a mother. I didn't want to fail. If I fail not only I fail myself, I fail the baby.'* (Participant 2, line 428).

This woman continued on to say:

*'...yes, being a mother, that identity thing, it's so important and you don't want a stained identity, would you? Like to be known because you are a*

*murderer. You just want to be known as -- in a positive way, not in a negative way'. (Participant 2, lines 720-722).*

Having 'choice' and 'independence' served as a protective factor. Women described this in the context of being able to work and gain an education, which appeared to give them a sense of purpose, one woman said:

*'That's (work and education) very important because I won't just stay home, look after all the children being a housewife not helping out. What if anything happens to the bread winner?'* (Participant 4, lines 366-367).

In summary the data analysis of the interviews revealed that the concepts of resilience, access to rights and support and identities were inter-related and were directly influenced by cultural and societal influences, experiences of war, and the psychological effects of these experiences. The analysis suggests that women in this sample were striving to reconstruct new identities which certainly appeared to strengthen their resilience to take action to access support if required to rebuild their lives.

## **2.5 Discussion**

This study aimed to explore the unique perspectives of African women refugees who have experienced violence in the context of war. It also aimed to gain an understanding of the impact of these experiences on mental health and understand

the roles of resilience in African women and its relationship to identity. Figure one illustrates the model developed from grounded theory analysis of the interviews.

The current research contributes to an understanding of the experiences of African women refugees in the context of war. The use of a qualitative methodology allowed women to identify some of the difficulties and coping strategies and their impact on resilience. Analysis revealed that societal and cultural influences have a strong impact on women's ability to cope. Traditional and societal views of women and the stigma attached to sexual violence in Africa served to silence women, which often prevented them from accessing other forms of support. This broadly supports the findings of McMichael and Manderson (2004) who found that refugees who used established social networks were better able to access social and material support and tended to suffer less psychological distress.

Women described a number of psychological effects which could be understood as symptoms of PTSD. However, data analysis revealed that although African women interviewed in this study reported psychological effects of trauma, a diagnosis of PTSD cannot fully account for understanding the impact of war on these African women refugees. It does not take sufficient accounts of their culture, context, gender and resilience and identity, as others have also argued in the context of Uganda and Mozambique (Liebling-Kalifani, 2008; Sideris, 2003). Women were reportedly able to deal with their symptoms on their own and this appeared to be helped by accessing practical support to rebuild their lives. It is important to note however that none of the women in this study had disclosed severe violence or sexual violence themselves, and therefore interpretations of this data should be treated with caution.



A number of salient coping strategies were employed by women in the current study such as accessing social networks, talking to close family/friends, seeking practical help and legal action for human rights abuses they endured. Equally women displayed remarkable inner strength such as cognitive appraisals e.g. positive self talk and positive thinking, as well as hopes for the future and religion/faith. These findings support the existing literature, for example Khawaja et al., (2008) found similar coping strategies in Sudanese refugees during pre-transit and post migration periods. Goodman (2004) equally illustrated the progression from helplessness to hope as well as positive thinking in Sudanese youth, a finding also supported by the current study.

Religion formed a major component of women's resilience. Halcon et al., (2004) highlights this as a common form of coping used by refugees from Africa and the results from this study are consistent with previous research findings (Gorman et al., 2003). Women described how they believed their fate was in God's hands and that a strong faith would bring them a better future.

Existing literature does not address the impact of identity on resilience and effects on the psychological health of African women. The current research however suggests a complex interaction between resilience, coping and identity and proposes a 'resilience mechanism' to illustrate their interdependent relationship. Liebling-Kalifani (2007) identified how women are able to reconstruct their identities following violence however its link to resiliency is not addressed in depth.

The current study identified how resilience appeared to fluctuate with women's sense of self. They valued their identities as mothers, providers and as women. If they felt these roles were in some way compromised, this devalued their sense of self and decreased their resilience and capacity to cope. These findings are important in terms of implications for service needs as women need to feel they have a sense of purpose or identity. This also reflects a need for women to be helped in terms of access to opportunities such as employment and education so that they can provide for their families and gain a sense of empowerment.

Interestingly analysis in the current research identifies the importance of women's later experiences in the UK and its impact on maintaining resilience. This is identified in the literature by Khawaja et al., (2008) as the 'post-migration phase'.

Findings of the current study suggest that there are a number of difficulties that serve to hinder women's ability to rebuild their lives in the UK, for example access to practical support and advice, education, housing and employment. The salience of these factors has previously been reported by Miller et al., (2002) in their study on exile-related stressors among Bosnian refugees. Interestingly all of the women interviewed in this study expressed a desire to access education as they felt this would improve their future. This contradicts findings by Miller et al., who found that many refugees felt a sense of hopelessness and felt it was too late to start new meaningful life projects. This however may reflect cultural differences in aspirations of refugees.

Difficulties during the asylum seeking process in the UK served to decrease resiliency and coping, largely due to the fact that women were unable to access these

services until permission had been given to remain. Women reported not knowing who they were during this process which instilled feelings of uncertainty about the future and fear of being sent back which women felt affected their ability to cope and increased psychological distress.

Literature has highlighted the negative impact of refugees not being able to practice their religion in post-migration environments (Eisenbruch, 1991). However in the current study women did not discuss any difficulties in being able to practice their religion, this may be because the predominant religion in Zimbabwe is Christianity and women may have felt more able to practice their religion in the UK as Christianity is adopted by many British citizens. This may also contribute to explanations about the amount of resilience displayed by women in the current study, it may be that the culture in Zimbabwe is not too dissimilar to that of the UK and may have eased the transition into UK life.

Although a number of findings support the existing literature there are a number of new and important issues to emerge from this study, in particular the links between identity and resilience and its importance in recovery from traumatic experiences. The current study also identifies important factors in maintaining the resilience of African women and suggests building on women's sense of empowerment by providing equal opportunities that serve to reconstruct identity and allow a smooth transition into life in the UK.

### *2.5.1 Methodological Limitations of the Study*

A number of questions arise over the generalisability of both the findings and interpretations of the current research. Specifically, the study employed just six participants; this not only highlights the sensitive nature of the study but also illustrates the reluctance of refugee women to talk about their experiences and the importance of creating a good rapport when working with this population. Similarly, all but one of the women interviewed were from the same African country. The results of the study therefore need to be interpreted with caution as they cannot be generalised out to the African population of refugees in the UK as a whole. Future studies would benefit from utilising a more culturally varied sample to increase the validity and reliability of results.

All women interviewed had been given leave to remain in the UK, which may have influenced their perceptions of their resilience and psychological health. Questions arise as to whether the findings would have been the same if participants did not have the 'security' of this status.

Despite the researcher's attempts to build a rapport with the women prior to interview, participants may have remained cautious and shared only general experiences. It is important to note that none of the women disclosed personal experiences of rape or sexual violence and only two reported personal experiences of physical violence. Psychological symptoms may have been more severe in women who had been survivors of gender-based violence themselves which might have had a greater impact on resilience and identity.

### *2.5.2 Implications for Clinical Practice and Future Research*

The current study contributes to an ongoing shift from the medical model of trauma toward a more holistic model of understanding African women's experiences, which is culturally and gender sensitive. Future research could usefully test the model developed in the current study on a larger scale and within different cultural groups.

The study elicits findings that have implications for responding to the mental health needs of refugees, in particular by a greater understanding that women in this context demonstrate resilience in the face of adversity, and are indeed survivors and not victims. Mental health services need to recognise these strengths and build on them in order to assist women refugees to access their rights to health, service provision and justice. Health services should be provided which support women's further empowerment and utilise a rights approach which further builds on their resilience (See Grown, Rao Gupta and Pande 2005). The current study also recommends that services for African women refugees needs to adopt a multi-agency approach that helps women to access their rights and health services as well as education and employment. Equally a culturally sensitive approach is essential being mindful of women's unique abilities to rebuild their lives and the wider community in their recovery. In this sense, as other researchers have found (Liebling-Kalifani et al., 2007) therapeutic groups may have an important place for refugee women seeking help in the UK.

Future research could helpfully evaluate therapeutic and support groups for refugee women war survivors. Other studies might continue to explore the factors associated with trauma but with a view to differentiating between pre-migration and immigration experiences.

Women interviewed in the study often referred to the 'stigma' of sexual violence and traumatic experiences. Literature exploring stigma in this area is scarce however it remains a huge problem for refugees and often deters them from accessing mental health services in western countries. Therefore it is also recommended that further research continues to understand stigma and its effects and how this can be addressed more effectively within services. Research is beginning to address gender-based violence directed at men, it would therefore be of interest to explore gender differences in resilience and coping. Men and women experience GBV differently and therefore may exhibit different coping strategies.

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# **Chapter Three**

## **Experiences of Conducting Research with Refugees: Reflecting on the Process**

**Target Journal: Psychology of Women Section Review**

**See Appendix (A) for instructions for Authors**

**Word Count (Excluding tables, figures and references): 3322**

### **3.1 Introduction**

The aim of this paper is to explore and reflect upon my research journey. It particularly covers reflections on methodological and ethical issues relating to conducting research with African women who have experienced violence and abuse, as a result of conflict in their native countries. Although their experiences have resulted in psychological and physical health problems, I was interested in the theoretical concept of 'resilience' and what assisted them to deal with their experiences.

As part of an agreement with the refugee centre I was required to complete initial training and volunteer as a caseworker working there for four hours a week over a six month period. Throughout my time at the refugee centre I kept a journal of my experiences and this paper draws on some key themes emerging from this. The journey of carrying out my research was extremely challenging at times yet also rewarding, providing a huge personal development curve for me. I was able to learn things about myself and about others, as well as challenge some stereotypes and prejudices. Overall it was a humbling experience I will remember and hope to build on in the future.

### **3.2 Choice of research area**

My reasons for choosing this research area emerged from an interest both professionally and personally. Throughout my work as an Assistant Psychologist and more recently as a Trainee Clinical Psychologist I have been intrigued at what

prompts some people to seek psychological help and others not to following traumatic experiences.

I am always moved when hearing reports through the media about the atrocities in developing countries where rape and murder take place on daily basis, often so brutal and torturous it is perhaps incomprehensible to western cultures. In many of these countries there is little justice for survivors of atrocities, no money for financial support or compensation and very few if any health and support services to help them process their traumas. This is in stark contrast to the western world where although inequalities in healthcare still exist, support, money and multiple services are generally available to most survivors. In the United Kingdom it is not 'usual' for mothers to be forced to sell their children to brothels, to be physically mutilated and endlessly raped in their place of work or by people in authority who are supposed to protect them. Women are not shunned by their families for having been raped or infected with HIV every day. However, in developing countries of Africa, these experiences are 'normal' everyday occurrences but because it is so frequent does that make it any less traumatic for the survivor?

I felt it was important to reflect on my assumptions of what a 'developing country' was. Prior to commencing my research I wrongly assumed that Africa as a whole was economically and socially under developed, however I soon learned that what maybe be seen as a developing country in western 'developed' countries like the UK may well be seen as normal in Africa. The designations 'developed' and 'developing' are usually intended for statistical convenience rather than a stage reached by a particular country or area in the development process. Not all countries

in Africa are 'developing'. Africa is a vast continent and hugely diverse, not all countries in Africa are war torn and it is therefore important to be mindful of western assumptions. It was important to be aware that I was researching specific war torn countries and I needed to try not to generalise my findings to an understanding of life in Africa as a whole.

This interest led me to my academic supervisor who has been working in Uganda for over ten years with women war-torture survivors who have suffered violence and abuse. I initially planned to travel to Uganda to carry out my research with a colleague as I wanted to have a research experience within an African environment and gain a deeper understanding of their lives and cultural context. However, permission was not given and following initial disappointments my research was carried out at a local refugee centre instead.

### **3.3 Methodological Issues.**

#### *3.3.1 Recruitment*

The recruitment of participants was a particular challenge throughout my research, which proved quite stressful. From the onset I was met with some resistance from staff at the refugee centre who were understandably initially concerned about asking women to discuss their traumatic experiences. I explained my research in staff meetings but was disappointed to learn later that some staff were unwilling to administer leaflets about the study in my absence. Perhaps on reflection I could have spent more time with staff explaining my role as a Trainee Clinical Psychologist and

my training in forming relationships with clients and handling sensitive subjects. (Renzetti and Lee, 1993).

Over the ensuing months, I experienced what I describe as ‘waves’ of emotions and a rather ‘stop-start’ approach to interviewing participants. I would feel hopeful when booking in interviews however I soon learned not to get my hopes up as participants tended not to attend scheduled interviews, and as a result a number of interviews fell through. In addition to the increasing costs and time constraints of travelling a considerable way, this process left me feeling somewhat discouraged.

### *3.3.2 The Process of Interviewing*

Oakley (1999) advocates adopting an ‘interactive’ interviewing stance to minimise ‘objectification’ of participants. This involves regarding the interview as an ‘exchange’ where the researcher and participants engage in an interactive dialogue; the aim of which is to personalise and humanise the researcher and place the researcher and participant on a more even footing. During my research, this is an approach I attempted to utilise. However my inexperience with the method led to some initial difficulties. I felt anxious before my first two interviews possibly because of the difficulties in recruiting as well as the fear of not gaining enough information. I felt it was important to establish rapport with participants in order to be able to go on and discuss sensitive subject areas, and so at the beginning of each interview I would initiate an informal discussion in an attempt to create a trusting relationship before the interview started. However this did not always prove to be a useful approach as I would then find it difficult to move on from this more informal ‘light-hearted’ discussion to a sensitive and potentially upsetting interview, indeed I would often find myself still talking fifteen minutes after meeting participants.

I am aware that this initial conversation was a reflection of my anxieties and perhaps my fear of moving on to discuss more sensitive topics; this is evident within my speech for the first two interviews where I tend to hesitate and stutter more frequently. I was also mindful of my anxieties and was aware it might hinder the quality of the data I got from interviews. I think my anxiety may have been picked up in the interviews and possibly deterred women from going into too much detail about their experiences, equally I may have avoided asking certain questions because I felt I was being too intrusive. On reflecting why that may have been I recalled being informed by some staff at the refugee centre that participants might not like talking about their experiences, although I am faced with these dilemmas in my work as a clinical psychologist my unfamiliarity with this group of clients and perhaps prior attitudes that refugees were somehow 'different' to the general population increased my fear of upsetting them.

The process of recruitment for the research meant I had not always met with participants prior to the interview and I had no way of knowing what they were going to disclose. For the first few interviews I felt uncomfortable with 'not knowing.' However, as the interviews progressed I felt more comfortable and was able to gauge how well a participant would accept and respond to questions. Surprisingly I found that despite pre-conceived ideas, participants were very motivated to talk about their experiences, some even reporting that they found it a very therapeutic experience. I gained more of awareness that these women found it empowering to tell me their stories and it felt rewarding to be part of that process.

I attended a women's group at the refugee centre on a couple of occasions and as part of the research process I had initially envisaged conducting a focus group with the women in this group. However due to low attendance at the group and time constraints with my research I was unable to do this. Willig (2001) discusses the importance of establishing a good rapport between the researcher and the participant so that there can be a greater flexibility and coverage of information. I feel that if I had been able to conduct this focus group it might have provided the women with a sense of familiarity with the process and me, which may have then encouraged more women to come forward for interview. The group may have also allowed me to become more familiar with potential participants and allowed a relationship to have developed prior to interview, which could have reduced anxieties on both parts.

### **3.4 Ethical Considerations**

I was eventually able to spend more time at the refugee centre and felt I could be more of an active agent in recruiting participants and was able to make more of an initial connection with potential interviewees. Following completion of the research, I reflected that the use of the word 'interview' may have deterred women from taking part as many refugees are interviewed at length by the Home Office during the asylum process. These interviews often determine whether they are deported back to their home countries and therefore cause great anxiety. However, once I described the interview as a discussion, more women were willing to take part and this made me realise the importance of wording and language in my information sheets. Despite being made clear about the interview not affecting the service they received from the refugee centre, participants were undoubtedly affected by their

past experiences of the asylum process as well as their traumatic experiences, which caused them to be very weary of unfamiliar people.

Some women brought their children to the interview and in this situation I had to be aware of how I asked participants questions as I did not want to risk upsetting the women in front of their children. On reflection I wonder whether this might have been an unconscious attempt by the participant at ensuring difficult questions weren't asked or having a familiar face in the room with them for security or comfort. I recall feeling frustrated when this happened as it meant that interviews were often interrupted. However, I had to be aware of striking a balance between my need to conduct a 'successful' interview and ensuring it was carried out ethically, respecting the needs and wishes of the participants.

### **3.5 Case working at the Refugee Centre**

I felt I learnt a great deal whilst working at the refugee centre, professionally and personally. Initially I found the transition from 'psychologist' to 'caseworker' quite challenging, I had to refrain from asking about client's backgrounds and experiences as I would usually do as a trainee clinical psychologist seeing client's in the health service and I was also mindful that my role was to offer practical advice and act as an advocate for clients with problems such as accommodation and filling out necessary forms to access financial support. The 'matter of fact' approach to working with refugees didn't sit comfortably with me as I was compelled to find out how they were coping emotionally with the process of seeking asylum.



My assertiveness skills were challenged as I found liaising with organisations and the Home Office to be particularly frustrating. For example being left on hold on the telephone for long periods and dealing with uncooperative staff members. I am aware that I can sometimes find confrontation difficult and I knew that this would test me. However, this experience gave me a lot of insight into how refugees feel when met with resistance. I also learnt more about the difficulties faced by people who are merely trying to feel safe in a foreign country when their first language is not English.

Through working closely with refugees I found myself reflecting on and challenging my own stereotypes and prejudices I have had about refugees and asylum seekers. My experiences highlighted how traumatic and anxiety-provoking the process of gaining asylum is, which I had not previously realised. I learnt of the trauma refugees experience not only in their native countries but in getting to the United Kingdom. I found it difficult to comprehend how desperate refugees must feel to separate themselves from their families and put their lives in danger by clinging onto the undercarriages of lorries often for days in the hope of a new life in the UK, only then to be faced with complicated and lengthy 'hoop jumping' to try and ensure their security and safety in an unfamiliar country. I developed a new appreciation for the experiences of refugees and felt a little guilty at the lack of empathy some westerners can show to those seeking asylum.

Perhaps the most challenging experiences at the refugee centre for me was accepting when I couldn't help a client. On occasions refugees would arrive at the centre at the end of the day with nowhere to stay. I experienced feelings of helplessness,

inadequacy and at times felt completely powerless to help them. Having to accept that sometimes I couldn't help was difficult to process. I have experienced this in my training yet I am able to be more accepting when this happens. However, experiencing this at the refugee centre felt completely different and very 'real' maybe my unfamiliarity as well as the injustice of their situation made it more difficult for me to accept.

The following extract from my reflective diary sums up a common situation I came across whilst working at the refugee centre:

The time was 5pm. I was about to finish when a young family arrived at the centre. I went to the waiting room to find them sat in dimmed lights surrounded by bin liners full of clothes. The parent's looked up at me with a look of sheer desperation with their little girl, perhaps no more than three years old playing with a doll. I immediately felt their pain and brought them up to the office. They were from The Democratic Republic of Congo and had arrived in Coventry expecting friends to put them up whilst they made their asylum applications. Their friends were not answering their telephone and they had nowhere to go...they were sat amongst everything they owned.

The father pleaded with me to get him and his family accommodation for the night. Already feeling inadequate I looked at my manager in the hope of being able to offer them something but he shook his head. Pleading with local hostels was futile - it was the end of the day and everywhere was occupied for the night. I felt guilty as there was nothing I could do and my heart sank for the family. Tears appeared in the mother's eyes and I felt emotional as I looked at their daughter who was sat playing with a pen and paper seemingly 'oblivious' to the situation, she occasionally looked up at me and offered me her drawing, giggling.

Eventually we were able to get them emergency accommodation with social services that were able to put them up for the night. As I drove home I couldn't help but wonder what the future held for this family.

Excerpt from reflective diary, lines 230-257

However my work at the refugee centre was not always so disheartening and I found the women's group to be an uplifting experience. Yalom (1995) describes

a sense of 'universality' as a therapeutic factor during group therapy; a feeling of sharing problems similar to others and a sense of not being alone. This was clearly evident in the women's group at the refugee centre and seeing groups of women coming together to share similar experiences, supporting each other and witnessing their strength was an incredibly humbling experience. Equally, Liebling-Kalifani (in press) in her work in Luwero, Uganda has found that groups for women war survivors provide a safe place to share traumatic experiences and this has had positive outcomes.

In contrast to the clients seeking asylum these women and children were often laughing and working on re-building their lives, this represented a more positive side of my experiences at the refugee centre. One of my participants told group members about our interview describing it as 'a liberating experience' she said she had realised that she still had 'a bug to bear' and once it came out during the interview she reported feeling 'relieved' and 'free'. It was rewarding being part of this process and made me realise the importance of having the opportunity to speak out.

I was surprised when looking through my reflective diary at how frequent the words 'stress' and 'emotional' came up for me. I reflected on why this was and wondered if it was connected to my values of completing my research and handing in on time and also my feelings of disappointment at other's resistance and reluctance to help during the research process. I had a number of obstacles and 'hoops' to jump through, which at times were draining and tiring and led me to feel quite emotional, which surprised me as I've always felt I have a relaxed approach to work. Support, both personal and professional was an important aspect to the research. Working

alongside a colleague proved invaluable as we were able to seek support from each other. I was aware of the impact hearing participant's accounts of their experiences had on me and I needed to be aware of my responses to them. Similarly with case working, feelings of inadequacy, guilt and frustration were common at times, it was therefore important to de-brief afterwards which I was surprised to learn was not routinely offered at the refugee centre. However through supervision and support from my colleague I was able to ensure this was in place.

I believe my own resilience was tested at times and I reflected on my experience thinking that it wasn't too dissimilar to that of the refugees. I was someone new working for the refugee centre, no-one knew me or understood my background and I was trying to make people aware of why I was there trying to get people to understand that I needed their help. I felt frustrated that people did not understand and were sometimes resistant, which was similar in some ways to the feelings of the refugees I saw who found themselves in a new country where often people are not prepared to help or offer support.

### **3.6 Concluding remarks**

Overall the experience of case working and carrying out research at the refugee centre has been extremely valuable and despite difficult encounters and obstacles I found it to be positive. I hope to continue my research in this area and finally get to work with war survivors in Uganda or other areas of Africa. I feel my experience during this research process has prepared me well for this. I learnt the importance of

recognising my own prejudices and values and had to acknowledge that my belief systems might be different to my research participant's.

Future research in this area could benefit from attention to some of the methodological and ethical issues highlighted in this paper. The further development of qualitative methods that assist with research in this area would be helpful as well as the role of reflexivity in this process as advocated by Dallos and Stedman (in press) Despite the very sensitive nature of this research topic women survivors generally felt empowered after narrating their experiences during the research which they found was therapeutic in itself.

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## **Appendices**

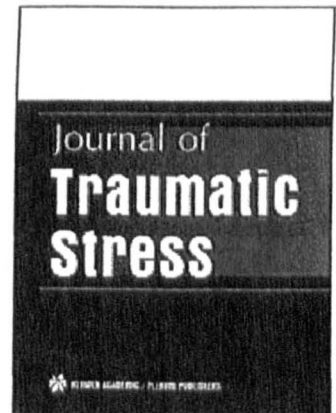
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### *Book*

Kelly, J. A. (1983). *Treating child-abusive families: Intervention based on skills-training principles*. New York: Plenum Press.

### *Contribution to a Book*

Feindler, E. L., & Fremouw, W. J. (1983). Stress inoculation training for adolescent anger problems. In D. Meichenbaum & M. E. Jaremko (Eds.), *Stress reduction and prevention* (pp. 451—485). New York: Plenum Press.

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*Only completed work should be submitted. The editors cannot provide feedback on work in progress.*

*Abstracts and key words should be included in the same file as the article.*

*Authors should include a key word or phrase about their research methodology.*

*The maximum length of any contribution should be 7,500 words, inclusive of notes and bibliography.*

*Contributions should be double-spaced, including all notes and references. Page numbers should be placed in the upper-right corner, paragraphs should be indented, and all illustrations and tables*

*should be labeled and captioned accurately. Use Times New Roman, 12 point font, left-justified text, and bold-faced headings. Follow APA or MLA citation styles.*

*All submissions should include an abstract of 300 words or less and three key words suitable for indexing and abstracting services.*

*Final submissions following revisions should be single spaced; right justified; bold headings with no space between heading and paragraph including title and abstract; the phrase key words should be italicized; references/bibliographies should be single spaced with hanging paragraphs. Authors should consult recent editions for guidelines and send inquiries to the editor.*

*In the interests of double-blind reviewing, only the title of the paper should appear on the first page. Authors should include their name and affiliation and any acknowledgements on a separate page.*

*A brief biographical note of not more than 80 words about each author should be supplied on a separate page.*

*Contributors should bear in mind the international nature of the journal's audience. Endnote explanations are necessary for all political & geographic references, popular culture references, as well as academic references. Please do not assume that scholars who are famous in one country bear similar prestige elsewhere.*

*Submission of work to this journal will be taken to imply that it presents work not under consideration for publication elsewhere. On acceptance of work, the authors agree that the exclusive rights to reproduce and distribute the article have been given to JIWS.*

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# Psychology of Women Section Review

## Notes for Contributors

1. All papers and submissions for the Agora section will be peer-reviewed.

2. Three hard copies of all submissions, plus a disc copy or e-mail attachment (in Word or WP for Windows or ASCII/RTF formats) should be submitted to the Editor (or Assistant Editor, where specified). A separate cover page should be provided with the title of the paper, the author's names, their institutions, addresses and telephone numbers clearly marked. *Authors are also invited to provide brief biographical information.*

*Manuscripts should have the title clearly marked on the first page, and pages should be numbered. However, authors' names should not appear on the manuscript itself.*

3. All figures should be of reproducible standard. References should conform to the American Psychological Association (APA) system, i.e.

Cobb, J. & Grey, S. (1979). The behavioural treatment of obsessive compulsive disorders.

*Behaviour Research and Therapy*, 17, 467–468.

Moore, S. & Rosenthal, D. (1993). *Sexuality in adolescence*. London: Routledge.

Hodgson, R.J. & Rollnick, S. (1989). More fun, less stress: How to survive in research.

In G. Parry & F. Watts (Eds.), *A handbook of skills and methods in mental health research*.

London: Lawrence Erlbaum.

4. Papers should be between 3000 and 6000 words long, and submissions for the Agora between 500 and 2000 words. An abstract of up to 150 words should be provided with papers, however, no abstract is needed for Agora submissions.

5. Book reviews and reviews of research papers will normally be commissioned by the relevant Assistant Editors. Anyone interested in reviewing books or research papers should contact the relevant Assistant Editor directly.

6. Authors should avoid the use of any sexist, racist, heterosexist or otherwise discriminatory language. The views expressed in this publication are those of the authors, and not necessarily those of the organisations or institutions that they work for.

Please send all correspondence to:

**Lindsay O'Dell**

**School of Applied Social Sciences,**

**University of Brighton,**

**Falmer, Brighton BN1 9PH.**

**E-mail: [lj.odell@brighton.ac.uk](mailto:lj.odell@brighton.ac.uk)**

**Appendix 2:**  
**Ethical Approval**

**(a) Coventry University Ethical Approval**

**(b) Informed Consent**

# COVENTRY UNIVERSITY ETHICS COMMITTEE (CU Ethics Form 1)

## POSTGRADUATE STUDENT & STAFF APPLICATION FOR ETHICAL APPROVAL

<b>Name</b> Kate Sherwood		<b>E-mail</b> katesherwood20@hotmail.com	
<b>Designation / Subject &amp; Faculty</b> Trainee Clinical Psychologist, Clinical Psychology Doctorate, Faculty of Health and Life Sciences			
<b>Title of Study</b> <b>A Grounded Theory Investigation into the experiences of Women war survivors in Africa: Effects on Resilience and Identity - Implications for Service Provision.</b>			
<b>1. Summary of proposal</b> This study aims to explore the experiences of women war survivors in Africa and to investigate the relationship and effects on resilience and identity. The research will provide new information about women's' resilience and coping strategies. It will also further our understanding about what assists people to recover from traumatic events and therefore provide new clinical information. In terms of mental health provision, the study also aims to provide useful information that can be utilised by services in African countries and adapted for services for African refugees and war survivors in the UK. This in turn will help professionals deliver more culturally appropriate services.			
<b>2. Sample of participants</b> A sample of 8-12 African refugee women will be interviewed using a semi-structured interview schedule and a larger sample of African men and women will be asked to complete the Changes in Outlook Questionnaire.			
<b>3. Site/s location</b> Men and women completing the questionnaire and women being interviewed will be recruited and interviewed at the Coventry Refugee Centre. This study has already received approval from the refugee centre management committee.			
<b>Tick / Cross. *Where answered 'NO', please give reasons on separate page.</b>		<b>Yes</b>	<b>No*</b>
<b>4. Scientific background, design, method and conduct of the study.</b> a) Have you given a justification for the research? b) Have you commented on the appropriateness of the design, the perceived benefits, risks and inconveniences to participants?		√	
<b>5. Recruitment of participants.</b> Have you provided a comprehensive account of the characteristics of the population including the process for obtaining access as well as the inclusion and exclusion criteria?		√	
<b>6. Care and protection of research participants and researcher.</b> Have you given an account of any interventions, situations and risks which have the potential to cause harm to the participants and researchers?		√	
<b>7. Access, storage, security and protection of participants' confidentiality.</b> Have you identified who will have access to the data and what measures have been taken to ensure confidentiality and compliance with the Data Protection Act?		√	
<b>8. Informed Consent.</b> Have you given a full description of the process for requesting and obtaining informed consent?		√	
<b>9. Community considerations.</b> Have you considered how this study will benefit the participants or the community from which they have been drawn?		√	
<b>10. Participant information Sheet and consent form. (version 1)</b> Are these attached?		√	
<b>11. Source of External Funding if any</b> Not applicable.			
Signature of student / staff		Address	Date
Signature of Supervisor		Print Name Internal Address	Date

Signature of Chair	<i>1 M full</i>	<input checked="" type="radio"/> Approved. <input type="radio"/> Approved with the conditions below:	Date <i>13/11/08</i>
Conditions / Comments:			

Please complete in full and return to: **Research Manager, CU Ethics Committee, Richard Crossman RCG 17, Coventry University.**

This form should be accompanied by the full research study proposal, or the COREC form if applicable. Further help & information can be found on W / HLS / Student / Ethics or call Satwant Sandhu on 024 7679 5813, or e-mail [sandhu@coventry.ac.uk](mailto:sandhu@coventry.ac.uk).



Participant identification number:

CONSENT FORM

Title of Project: A Grounded Theory Investigation into the experiences of Female war survivors in Africa: Effects on Resilience and Identity and Implications for Service Provision.

Name of Researcher: Katie Sherwood

Please initial box

1. I confirm that I have read and understood the information sheet dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason and that this will not affect the service I receive from the Coventry Refugee Service in any way
3. I confirm that I have given permission for the interview be audio-taped and that I have been informed about the possibility of exact quotations being used in the writing up and publication of the research.
4. I have been informed about how my information and data will be identified, stored and used confidentially as part of the research study.
5. I agree to taking part in the above study

Name of participant

Date

Signature

Name of person  
taking consent

Date

Signature

**Appendix 3:**  
**Interview Schedule**

## **Interview Schedule**

- 1. Can you tell me a little about yourself/your experiences in Africa and the reasons why you have come to be in the UK**
- 2. Can you tell me a little about your Experiences in Africa?**
  - Where were you living
  - What happened to you/friends/family
- 3. How did this affect you?**
  - Emotionally
  - In your relationships
  - Culture
  - Identity – sense of self
  - Socially
- 4. Have your experiences changed you in any way?**
  - Positive
  - Negative
  - Has it changed your outlook on life? How?
  - Has it affected you physically? How?
- 5. What helped you to get through these experiences?**
  - What helped you to cope?
  - What didn't help you?
  - Can you tell me about any particular strategies that helped you?
  - What do you think made you strong inside
- 6. Have any other services helped you?**
  - What helped you emotionally
  - In your relationships
  - Culturally
  - In restructuring your identity/who you are
  - Socially
  - Practically
  - Legal action
- 7. Is there anything else you would like to tell me about your experiences?**

Thank you

**Appendix 4:**  
**Leaflet and Information Sheet**

### **Help Wanted African Women!**

Have you been affected by war in your native country? Would you be interested in sharing your experiences about traumatic events as part of a study exploring ways in which people cope with and make sense of traumatic experiences?

War can have a large impact on people's lives, everyone has their own experiences and it can affect how people feel emotionally and how they continue to cope in their lives after war has ended, particularly if they have witnessed or been through a traumatic ordeal. People deal with these experiences in different ways; some people find it extremely difficult and can be deeply affected by their experiences and some people find it much easier to think about and make sense of what happened.

Whatever your experiences I would like to hear from you so that I can gain a better understanding of what you have been through and find out what helps people get through these difficult times. Your story is important; the purpose of sharing these experiences with me is to help me gain a better idea of what helps people carry on with their lives and what helps them stay strong emotionally following such traumatic events.

In return for your help and participation a small token gift will be offered up to the value of £5 to aid travel costs.

If you would like to share your story with me or if you would like to find out more about the study I would be happy to hear from you.

Please contact me: Kate Sherwood or a member of the Asylum Team at:

Coventry Refugee Centre  
15 Bishop Street  
Coventry  
CV1 1HU

Tel: 024 76 22 72 54



Programme Director  
Doctorate Course in Clinical Psychology  
Professor Delia Cushway  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

### **Information about the study**

- **Study Title:**

A Grounded Theory Investigation into the Experiences of Women war survivors in Africa: Effects on Resilience and Identity - Implications for Service Provision.

- **Who is doing the study?**

My name is Katie Sherwood and I am a Trainee Clinical Psychologist at the Universities of Coventry & Warwick. I would like to interview you as part of my study.

My supervisors are Dr Helen Liebling-Kalifani, research tutor at Coventry University and Barbara Goodfellow, Counselling psychologist at Assist Trauma Service. Assist is an organisation that helps people who have suffered from trauma. Before you decide whether or not you would like to take part in the study it is important for you to understand why the research is being done and what it will involve, please take time to read the following information before making your decision.

- **What is the purpose of the study?**

The study aims to investigate the effects that war has on people and to find out what helps them deal with traumatic experiences. Some people are deeply affected by their experiences and find it very difficult to function in their everyday lives. People can also report positive changes following traumatic experiences.

My study looks specifically at women's experiences of war, gender based violence and how women cope with and make sense of what has happened to them. It is hoped that the information from this study will help to provide a better service to people who have suffered from trauma.

- **Why have I been chosen?**

I am currently working in collaboration with Jane Longville, manager of the Coventry Refugee Centre. You have been approached because I would like to interview you about your experiences in your native country. I am also interested in your experiences since arriving in the UK. I would also like to send a number of questionnaires out to men and women from African countries.

- **Do I have to take part?**

It is important to know that you do not have to take part in this study, it is entirely voluntary. If you decide that you would like to take part you will be asked to sign a consent form which will give me your permission to interview you. Should you wish to withdraw at anytime during the study you may do so without giving a reason, this will not affect the service you receive from the Coventry Refugee Service.

- **What will happen to me if I take part?**

If you choose to take part in the study you will be asked to complete a simple questionnaire which will ask questions about your experiences of trauma. Participating women will then be asked to take part in an interview which will last about an hour and a half and will invite you to talk about your experiences in more detail and about issues that are important to you.

The questions will be very general and open, you will be asked to talk about what happened to you and how you dealt with your experiences and what you found helpful or unhelpful in terms of support. Our interview will be tape recorded and transcribed and this will be kept strictly confidential i.e. I will not be sharing your responses with anyone else. Once I have analysed your responses I will be in touch with you again to give you the opportunity to comment on my findings.

If you have any concerns about being tape recorded we will be able to discuss this and find an alternative way of recording your answers if you would prefer. I understand it might be difficult at times to talk about your experiences and at anytime during the interview, it is OK to stop. If you decide you no longer wish

to take part you can say so and the tape will be destroyed. I will also provide a list of available support services if you are upset by anything discussed.

- **Expenses**

In return for your help and participation a small token gift will be offered up to the value of £5 to aid travel costs.

- **What will happen to the results?**

Your answers to the interview and the questionnaire will be kept with the other transcripts, I will be the only person who will be able to access this information, there will be no record of your name with your interview so your responses will not be identified as yours, instead you will be assigned a number and this will be locked away safely in a filing cabinet.

A copy of the main findings of the study will be sent to you and the findings will be published in a journal. Quotations may be used from interviews however these will not be identifiable in anyway and all data included in any publications will be anonymised.

If you have any concerns or questions you would like to ask please do not hesitate to contact me either by email or telephone, my contact details are given below.

Thank you very much for you time. Your help is greatly appreciated.

Katie Sherwood  
Trainee Clinical Psychologist  
Doctoral Programme in Clinical Psychology  
Universities of Coventry & Warwick  
Tel: 024 76 88 83 28  
Email: [katesherwood20@hotmail.com](mailto:katesherwood20@hotmail.com)

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Jane Longville  
Coventry Refugee Centre  
15, Bishop Street  
Coventry  
CV1 1HU  
Tel: 024 76 527 102



**Appendix 5:**  
**Interview Transcript**

336. *was it mainly sort of killing or were there attacks going on..... rapes or*

337. *anything like that...?*

338. Yes, of course, yeah, rapes, everyday. That's why my father and my

339. mother. They keep me house. They can do what ever you wanted after

340. rape, they can kill you

341. *So, that was quite common then as well?*

342. Yeah, many many children like my age . I know is raped, they will kill, he

343. will cut one arm and one leg and put it in front of the door family in the

344. morning, when his wake and he saw his little girl cutted with arm and leg..

345. *a little girl?*

346. Little girl or big, doesn't matter. He do what ever he want to do to people

347. *Wow.... so quite brutal*

348. Yeah

349. *and that's something you saw on a day-to-day kind of basis?... every*

350. *day?*

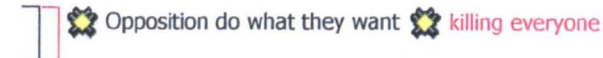
351. Yeah, every day... sometimes when I'm cooking and remembering....

352. every day I'm...everyday I'm trying to....(Somalian word).. trying to forget

353. about what happened you know, everyday I'm trying to be new friend.

354. And every time I'm go I'm try my children to be forgetting. I don't want her

355. to remember what happened to me but it's very difficult to forget



356. *And did anything ever happened to you?*

357. No, no, nothing ever happened to me. No

358. it happened to me like ....the same because my mum and dad are lik

359. me I'm not happened to myself you know. Its happened in my blood....

360. *yeah*

361. ....and that's problem but myself (clients name). I don't have any

362. problem

363. *so how have your experiences.... have they changed you in any way do*

364. *you feel that sort of having the experience that... awful.... atrocities that*

365. *happened there in Somalia has that made you into the person that you*

366. *are today. Do you think, in any way?*

367. *Hmmmm?....*

368. *Is there anything positive, that is sort of come out from your experiences*

369. Yeah, if I was to Somalia. Till now, because every person when we are

370. staying in this country. There are more opportunities coming, you know if

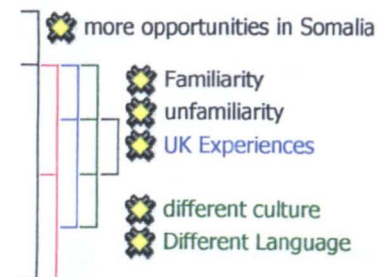
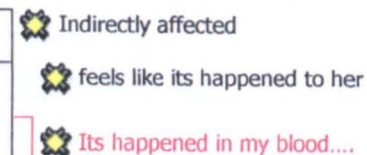
371. *you come in another country and have to learn first their language. You*

372. have to learn second their law you have to learn their culture. You have to

373. learn everything, but if you are in your country. Everything you know

374. already, you don't need to waste the time on other thing. You go where

375. what you wanna do I think if I'm still in Somalia. Till now, I will have more



376. experience, I think

377. *If you'd stayed in Somalia?*

378. Yeah, because if I'm going to school...now..... now, if I'm going to school.

379. I have to do finish English course first. And second and three. Then I go

380. to college and four, and I want future, but in Somalia. Everything I know,

381. you know, you understand what I mean

382. *Yeah*

383. Yeah

384. *and is there anything sort of. What's helped you sort of get through this.*

385. *How does it make you feel now. Now that you're here, or thinking about*

386. *your experiences back there. How do you feel now about it?*

387. I don't understand

388. *do you feel it's changed you in any way you feel stronger*

389. yes yes yes yes yes, I'm feeling stronger I'm grow up a lot with no family.

390. That's how I got it. I thought, if you don't do something good for you, who

391. can help you later on. That's how I got it. Yeah

392. *and what sorts of things, have you done has been good for you. That*

393. *helped you*

394. Be social be friends with everyone.... don't be alone with my own

395. *so, you find talking to people helps*

 UK Experiences

 Already know everything in own country

 Familiarity

 Wanting future


 Feels stronger

 Positive thinking

 Taking control of life

 don't be alone with my own

 lonely

 not being alone

 Social support

 support



396. yeah, all the times. Yeah. That's why my English now is good. You know,  
 397. that's why when I'm coming to UK I be with everyone I'm not stay only  
 398. with my country people I'm go to British people, I'm go to Pakistan people  
 399. I'm go to every country people to be friend to me

400. *do you find that gives you support*

401. Yes, yes, everyone knows my history and supporting me lot lot, lot of  
 402. people is supporting me

403. *... and that's how.....*

404. about advice, and he helped me to have everything what ever I ask of  
 405. them. And if I had.... I need to talk someone sometimes I remember I'm  
 406. think if I go there I'm talking. One British lady, very, very nice lady. She  
 407. helped me lot lot lot lot lot. Yeah, used to live, Birmingham. She lived next  
 408. door me buy she really nice woman

409. *In what way has she helped you.. get through this?*

410. Erm.. she helped forget that and nothing back to me and I'm safe country  
 411. now nothing come to push me. Nothing to do to me, and one day I can  
 412. have everything of my dreams. She helped me to teach in English. She  
 413. helped me to have a good life, whatever I wanted, but she was a very  
 414. nice lady. I never forget her I'm calling day and night even when I'm  
 415. coming to Coventry. She live Birmingham Way still, but still I'm calling all

☀ Talking helps  
 ☀ socialising with different cultures ☀ Social support

☀ Social support  
 ☀ support

☀ Practical help ☀ received advice  
 ☀ Social support ☀ Talking helps  
 ☀ not being alone  
 ☀ Social support

☀ Friend reassured her ☀ Talking helps  
 ☀ Social support  
 ☀ Friend instilled hope ☀ Hopes for future  
 ☀ support ☀ Practical help

☀ Maintaining social contact

416. the time. Say hello to her I'm sorry, she doesn't have any children.... she

417. really nice lady....

418. *And how has it changed the way you see life now how do you. How do*

419. *you view life now? compared to perhaps what you did. When you were*

420. *living back in Somalia*

421. I can't say more, because I didn't grow up with my family I'm grow up

422. here, you know I'm coming to another country. I can't tell what's different

423. *but my family's died when I was young, and I didn't grow over there you*

424. know? I can see anything, but I can see I'm now as free woman. I can do

425. whatever I want to. I can have the education I want to. I think like that.

426. Now...

427. *do you think education is an important part of just getting through, what*

428. *happened back there?*

429. Yeah, what I'm dreaming. Education is very very first with people, life,

430. education is good to have

431. *And by having that education. What does that allow you to do what...*

432. *what... how has that helped?*

433. .... you can get good job here, and a good life

434. *Yeah, so getting a good job allowing you to sort of rebuild*

435. yes yes yes

doesn't know any different

Family members dead

Has choice Independence

Positive thinking Education

Education

alright now

coming UK am getting better li..

Education

Employment

436. .... that's good .....
437. and has is it affected you in any other way at all.... has anything else
438. come up that you can think of that might have been useful for you
439. Useful? For what I will do? Is that what you mean
440. Yeah so sort of what helped you to ....what inner strengths then ....lets talk
441. about inner strengths what helped you get through it when you saw your
442. parents, and they'd been killed what helped inside you to carry on and get
443. through this
444. I'd be strong be strong and I'm lost all my think and be strong and be
445. good to myself. And forget what ever happened. I'm talking myself after, I
446. think to me. I'm locked in the room and talking myself. I say, be strong,
447. and you don't have anything or no one...
448. *Where do you find that strength from*
449. my head, and I know it's coming like that. I was so young, and I say, look,
450. if you think too much. You can be crazy. You can be having anything.
451. And now you've lost all your family. If you loosen your mind there is
452. problem. More problem and be strong, and be good life, and then you
453. stay alive you know...?

